EFFECTIVESS OF VIDEO ASSISTED TEACHING IN IMPROVING KNOWLEDGE ON PREVENTION OF ORAL CANCER AMONG PEOPLE RESIDING AT MANAMADURAI BLOCK, SIVAGANGAI DISTRICT, TAMILNADU.

A DISSERTATION SUBMITTED TO THE TAMILNADU DR. M.G.R MEDICAL UNIVERSITY, CHENNAI IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

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By

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MATHA COLLEGE OF NURSING

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ABSTRACT

STATEMENT OF THE PROBLEM:

A study to assess the effectiveness of video assisted teaching in terms of improving knowledge regarding the prevention of oral cancer among people residing at Manamadurai block.

OBJECTIVES:

- To assess the existing level of knowledge on the prevention of oral cancer among the rural population.
- To evaluate the effectiveness of video assisted teaching in terms of improving knowledge on the prevention of oral cancer among the rural population.
- To find out the association between the post test level of knowledge on the prevention of oral cancer and their selected demographic variables such as age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

HYPOTHESES:

- The mean post test scores on knowledge regarding the prevention of oral cancer among rural population who received video assisted teaching will be significantly greater than pre test score.
- There will be a significant association between the post test level of knowledge regarding the prevention of oral cancer and their selected demographic variables such as age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

MAJOR FINDINGS OF THE STUDY

- The majority of the subjects 27 [27%] were at the age between 18 – 25 years
- The majority of the subjects 55 [55%] were male.
- The majority of the subjects 44 [44%] were Hindus
- The majority of the subjects 66 [66%] live in rural settings.
- The majority of the subjects 63 [63%] were married.
- The majority of the subjects 30 [30%] have more than two children.
- The majority of the subjects 61 [61%] from joint family.
- The majority of the subjects 47 [47%] had a higher secondary education.
- The majority of the subjects 31 [31%] were government employees.
- The majority of the subjects 36 [36%] has monthly income of rupees 5000 and above.
- The majority of the subjects 69 [69%] take mixed diet.
- The majority of the subjects 51 [51%] have no habits of alcohol consumption, chewing betel leaves and smoking.
- The majority of the subjects 30 [30%] watch movies.
- The majority of the subjects 45 [45%] uses the communication media such as television, newspaper, posters and radio.
- The majority of the subjects 82 [82%] has no family history of cancer.
- The majority of the subjects 81 [81%] has no frequent exposure to radiation.
- Majority 61 [61%] subjects were having a moderate level of pretest knowledge regarding the prevention of oral cancer.

- ❖ Majority 79 [79%] subjects were having moderate level of post test knowledge regarding the prevention of oral cancer.
- ❖ There was a significant association between post test level of knowledge and selected demographic variables such as education and personal habits.

RECOMMENDATIONS

On the basis of this findings of the study, it is recommended that

1. A study may be done to assess knowledge of the urban population regarding prevention of oral cancer.
2. A comparative study can be done between urban and rural population on the knowledge regarding prevention of oral cancer.
3. A similar study can be replicated with larger sample size and in various other settings.
4. A study can be done to assess the quality of life of patients with oral cancer.
5. A study can be done by using different methods of teaching aids.
6. A comparative study can be done between male and female subjects in rural population.

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CHAPTER 1

INTRODUCTION

"All people smile in the same language"

- James Hook

The human face is a precious window to the world that emanates radiance, excitement, self confidence and happiness. Sadly due to oral problems, there are frowns and tears in their face where bright smiles and laughter should be. Today many people needlessly affected with oral cancer because they cannot obtain timely preventive, educational or treatment services. The burden of disease restricts activities in work, home and often diminishes the quality of life.

An oral examination often includes looking for leukoplakia and erythroplastic lesions which can progress to cancer. One recent study has shown that direct fluorescence visualization (using a simple hand held device) could identify subclinical high risk fields with cancerous or precancerous changes in the oral mucosa. Recent data suggest that molecular markers may be useful in prognosis for these pre malignant oral lesions. Although it is possible to detect and cure the disease at the early stage, most cancers are moderately advanced at the time of diagnosis, unfortunately this pattern has not changed over time.

Asian pacific cancer institute Beijing china 2000: oral cancer is one of the most common malignancies among betel nut chewers in South and SoutheastAsian countries. Although education for the cessation of the betel nut chewing habit is important, there are no adequate strategies and policies for primary prevention, health promotion and education related to oral cancer in rural areas.

There are several risk factors associated with oral cancers. Understanding these factors can help in preventing its onset.

- One of the prominent factors to be considered is the age (40 years).
- Most oral cancers can be related to the excessive use of tobacco and or alcohol.
- In India oral cancer has been linked to the use of betel nut chewing, cigarette or beedi smoking and the use of tobacco in products like gutka etc.
- Biological factors include viral and fungal infections, most commonly the human papilloma virus, particularly HPVI6 have been found to be associated with oral cancers that occur in the back of the mouth.
- Other than life style factors, there are also physical factors like exposure to ultraviolet radiation and exposure to x- rays.
- Nutritional factors like diet that is deficient in fruits and vegetables could become a risk factor.

The routine examination of asymptomatic and symptomatic patients can lead to detection of early stage cancers and premalignant lesions.

Most people don’t connect their mouths to the rest of theirbody. There is a link. Research shows that tooth decay (cavities) and periodontal (gum) disease may contribute too many serioushealth conditions. With mounting scientific evidence, the connectionbetween oral infections and other diseases in the body isbecoming widely understood and accepted.Gum disease and cavities are chronic, contagious oral infectionsthat can lead to major health concerns and negatively affectthe course of other diseases and treatments. Prevention is consideredkey to maintaining overall health. Proper oral careand regular professional scaling (cleaning) by a dental hygienistare important for keeping the mouth and body healthy.

Health Canada, The World Health Organization, the Ontariogovernment and data from international research continue toplace emphasis on health prevention and the knowledge that“the public cannot be healthy without oral health.”

NEED FOR THE STUDY

Cancer is one of the major threats to public health in the developed world and increasingly in the developing world. In developed countries cancer is the second most common cause of death. According to the world health report 2004, cancer accounted for 7.1 million deaths in 2003 and it is estimated that overall number of new cases will rise by 50% in the next 20 years. Oropharyngeal cancer is more common in developing than developed countries.

Oral health and its relationship to total health underscore the need toeducate consumers about the importance of quality preventive oral health care.

Research has identified periodontal (gum) disease as a risk factor for heart and lung disease, diabetes, premature, low birth weight babies and a number of other conditions. The 2000 Surgeon General's report, *Oral Health in America,* has called attention to this connection and states that, if left untreated, poor oral health is a "silent X-factor promoting the onset of life-threatening diseases which are responsible for the deaths of millions of Americans each year."

One of the most serious diseases found in the mouth is oral cancer. Often curable in its early stages, oral cancers are a major cause of death and disfigurement in the United States, according to the National Cancer

Institute. Oral cancer is more common than leukemia, skin melanoma, Hodgkin's disease and cancers of the brain, liver, thyroid gland, stomach, ovaries, and cervix. If caught early, it can be treated successfully; however, if not, it can spread into other parts of the body and become difficult, if not impossible, to treat. The oral cancer screening constitutes one of the most important components of a routine dental hygiene and dental exam.

Approximately 80 percent of American adults have some form of periodontal disease and the majority of them do not realize they have it, because in its early stages, it is usually painless. In view of the critical relationship of periodontal disease to overall health, and the staggering number of Americans who develop it, it is essential that the disease be prevented or detected early and treated aggressively.

WORLD SCENARIO

The prevalence of oral cancer is particularly high among men, the eight most common cancers worldwide. Incidence rates vary in men from 1 to 10 cases per 100,000 populations. In south central Asia, cancer of the oral cavity ranks among the three most common types of cancer.

The cancer is epidemic in developed countries, and increased in developing countries is due to the combined effect of aging populations, and the high or increasing levels of prevalence of cancer risk factors.

A J gross, D T lackland, medical university of south Carolina found that the use of smokeless tobacco is considered as a major risk factor for oral cancer. The epidemiology states there is a hypothetical association between the risk of oral cancer and the use of tobacco.

C D Llewellyn, July 2001 king's college dental institute London**:** They found out that genetic instability is a likely cause of oral cancer among older adults who have never smoked and consumed alcohol which are recognized as the common risk factors in older adults.

E Giovannucci, journal of national cancer institute 1999 the literature showed that high consumption of tomatoes and tomato based products was related to approximately half the risk of oral cancer.It has been estimated that 43% of cancer deaths worldwide are due to tobacco, unhealthy diet, physical inactivity and infections.

INDIAN SCENARIO

In India, the age standardized incidence rate of oral cancer is 12.6 per 100,000 populations. In Madurai there were around 12 new oral cancer cases for every one lakh population reported in a year.

Tobacco use and excessive alcohol consumption have been estimated to account for about 90% of cancers in the oral cavity. The oral cancer risk increases when tobacco is used in combination with alcohol or Areca nut.

The investigator during his field visit to the area he came to know that patients were affected bycancer which includes oral cancer. There is less awareness among the public regarding preventive aspects of oral cancer, so he decided to do this study.

STATEMENT OF THE PROBLEM

A study to assess the effectiveness of video assisted teaching in improving knowledge regarding the prevention of oral cancer among people residing at Manamadurai block.

OBJECTIVES

- To assess the existing level of knowledge on the prevention of oral cancer among the rural population.
- To evaluate the effectiveness of video assisted teaching in terms of improving knowledge on the prevention of oral cancer among the rural population.
- To find out the association between the post test level of knowledge on the prevention of oral cancer and their selected demographic variables such as age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

HYPOTHESES

- The mean post test scores on knowledge regarding the prevention of oral cancer among rural population who received video assisted teaching will be significantly greater than pre test score.
- There will be a significant association between the post test level of knowledge regarding the prevention of oral cancer and their selected demographic variables such as age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

OPERATIONAL DEFINITION

- **EFFECTIVENESS**

In this study it refers to gain knowledge regarding the prevention of oral cancer who attends the video assisted teaching program.

- **VIDEO ASSISTED TEACHING**

  In this study it refers to a series of slides that contains information /education regarding definition, causes, risk factors, signs and symptoms, treatment, diagnosis and preventive aspects of oral cancer and clippings that portrays the importance of prevention of oral cancer. The duration lasts for 45minutes and reinforcement was followed by the researcher.

- **KNOWLEDGE**

  In this study the knowledge refers to the understanding about the prevention of oral cancer which will be measured by a knowledge questionnaire.

- **PREVENTION OF ORAL CANCER**

  Oral cancer can be defined as an abnormal, malignant growth of tissue in the lip, mouth and oropharynx. Prevention refers to steps taken to avoid oral cancer.

- **RURAL POPULATION**

  In this study, rural population refers to people residing at milaganoor which is situated 7 km away from Matha College of nursing, Manamadurai.

ASSUMPTIONS

- The level of knowledge regarding prevention of oral cancer will be inadequate among rural population.
- Selected demographic variables may influence the knowledge regarding prevention of oral cancer among the rural population.
- Oral cancer will be common among person who has the habit of tobacco chewing, Smoking or Alcohol consumption for many years.

PROJECTED OUTCOME

- Present study would help to evaluate the knowledge regarding prevention of oral cancer among the rural population.
- This study would help to know the factors associated with oral cancer among the rural population.
- The study findings will be helpful in preventing oral cancer among the rural population.

CONCEPTUAL FRAME WORK

The conceptual framework for this study was derived from general system theory (Ludwig von bertalanffy). According to general system theory a system is a set of units interacting with each other with in a boundary that filters the kind and the rate of flow of inputs and outputs to and from the system.

General system theory is useful in breaking the whole process in to parts to ensure goal realization. The number of parts of the system is totally dependent on what is needed to accomplish the goal. Purpose, goal or aim is necessary for any system to function. The aim of the study is to improve the knowledge on prevention of oral cancer.

Berrtalanffy explained that the system has four major aspects.

1. Input
2. Through put
3. Output
4. Feedback

Input

Video assisted teaching with series of slides that contains information/education regarding definition, causes, risk factors, signs and symptoms, treatment, diagnosis and preventive aspects of oral cancer and clippings that portrays the importance of prevention of oral cancer. The duration lasts for 45 minutes and reinforcement was followed by the researcher.

Through put

It is the gain in knowledge through video assisted teaching regarding prevention of oral cancer

Output

It is the information that leaves the system and enters the environment through system boundary. It is the changes in the knowledge found among the subjects, which is interpreted as moderately adequate and inadequate level of knowledge.

Feed back

It is the result of throughput. On the analysis of the post test knowledge on prevention of oral cancer show that video assisted teaching should be modified or the same pattern can be followed once again.

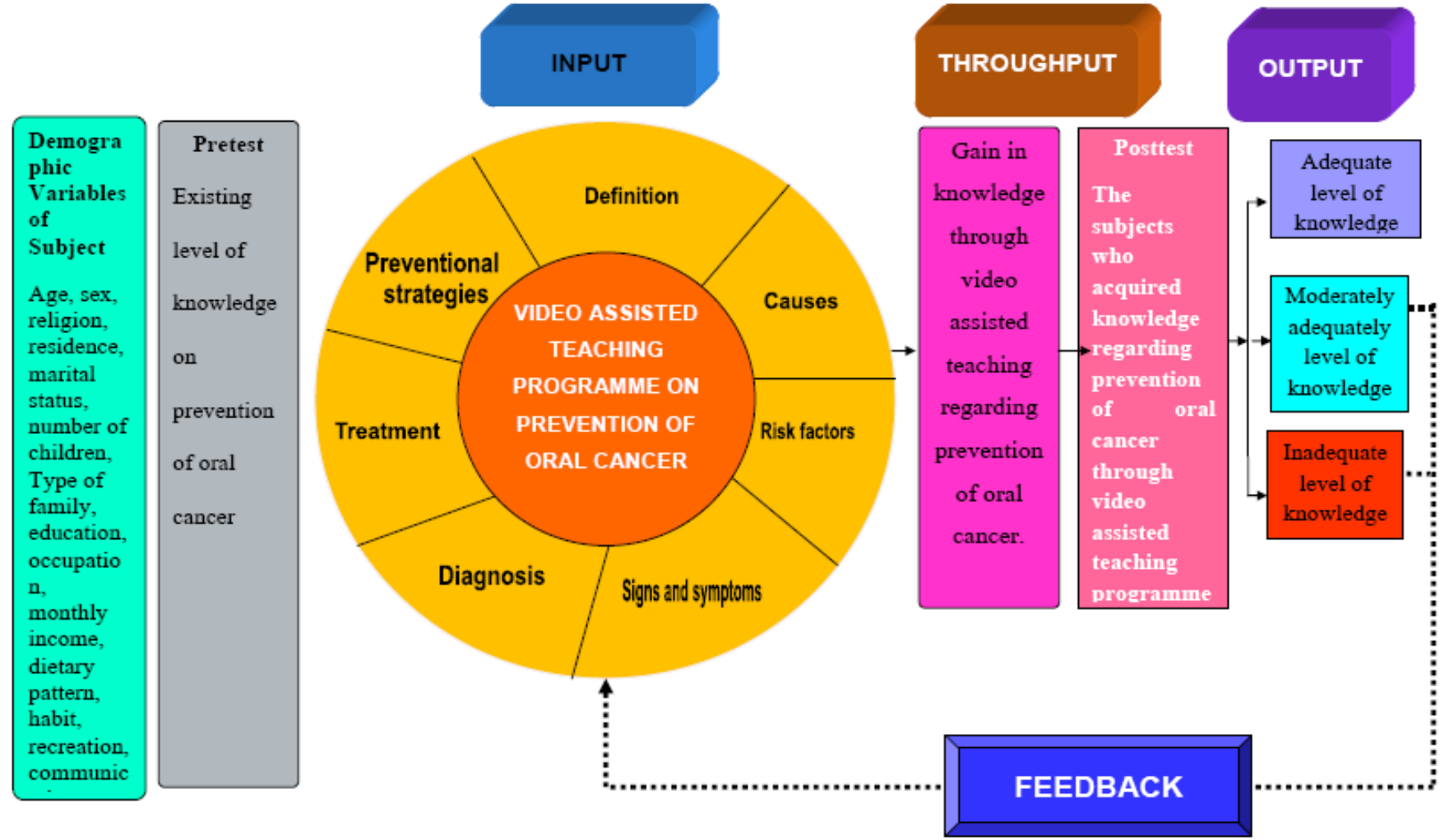

FIG:1 CONCEPTUAL FRAMEWORK BASED ON MODIFIED LUDWIG VON BERTALANFFY'S GENERAL SYSTEM THEORY

CHAPTER – II

REVIEW OF LITERATURE

The purpose of reviewing related literature in any fields is to help the individual to gain information about what has been already investigated, what methodology was used, what were the conclusions and what more needs to be done in the future. This chapter reviews some of the literature which is relevant and useful to the present study in identifying and focusing attention on the problems and the analysis and interpretation of data.

Amarasinghe H K et al (2010) did a study on public awareness of oral cancer, oral potentially malignant disorders and of their risk factors in some rural population in Sri Lanka, the study was to investigate the level of public awareness of oral cancer, of oral potentially malignant disorders and risk factors for developing these diseases in a province of Sri Lanka, a country with one of the highest incidences of these diseases in the world. The study concluded that, knowledge of oral cancer, oral potentially malignant disorders and their associated risk factors was poor among this population, indicating an urgent need to implement public health education and promotion strategies.

Johnson N W et al (2010) did a study on betel quid chewing with or without tobacco is a major risk factor for oral potentially malignant disorders in Sri Lanka. This study demonstrates a high prevalence of oral potentially malignant disorders, betel quid chewing with or without tobacco being the major risk factor.

LoheV K et al (2010) did a study on the evaluation of correlation of serum lipid profile in patients with oral cancer and pre cancer and its association with tobacco use. The study resulted that there was significant decrease is total cholesterol, high density lipids (HDL), VLDL, and triglyceride in the oral cancer group, and significant decrease in TC & HDL in an oral pre cancer group. Mean serum lipid profile levels were not significantly different in subjects between no habit of tobacco and with habit of tobacco.

Kalyani.R. et al (2010) did a ten year study in India about pattern of cancer in adolescent and young adults. This study resulted that cancer in adolescent and young adults accounted for 26.6% of all the cancers diagnosed. Maximum cases were seen between 35-39 years age group in both genders. The male: female ratio was 1:2. The top five most common sites in males wherecancer of the mouth, stomach, testis, bone and penis and in female weremouth, cervix uterus, breast, thyroid and stomach.

Swaminathan R et al (2009) done a population based study on education and cancer incidence in a rural population in south India. The association between education and cancer incidence has not yet been reported from India. This study concluded that men and woman with no education had higher overall cancer incidence rates compared to the educated population.

Abreu. L. et al (2009) did a 25 year retrospective epidemiological study on lip cancer in Western Australia, the aim was to report on the epidemiological trends in incidence and mortality rates of lip cancer in Western Australia from 1982-2006. The study reported that lip cancer represents 49 percent of all oral cancer cases. A total of 2,152 new cases and 31 deaths due to lip cancer are reported. The incidence rate of males

to females was 2.5 – 3.1. The mortality rates are very low indeed and are the reason for its good prognosis.

Bratoicheva M S et al (2008) underwent a study on the oral hygiene of patients with oral cavity cancer. The aim of the study was to establish the role of poor oral hygiene in the development of malignant lesions in the oral cavity. The accumulated evidence showed that oral cavity cancer is more frequent in men, rural residents and in the elderly. Oral hygiene is a factor in the development of oral cavity cancer.

Benard V B et al (2008) examined the association between socioeconomic status and potential human papillomavirus – associated cancers. The study showed that lower education and higher poverty were found to be associated with increased human papillomavirus associated cancer incidence rates. Race was an independent predictor of the development of these potentially human papillomavirus associated cancers.

Sadetzki.S. et al (2008) made a nationwide case-control study in Israel, about the cell phone use and risk of benign and malignant parotid gland tumors. The study was to find out the association between cellular phone use and development of parotid gland tumors. The methods were based on the international INTERPHONE study that aimed to evaluate possible adverse effects of cellular phone use. This study suggested an association between cellular phone use and parotid gland tumors.

In this study, cancer of mouth predominated in both genders, followed by stomach in males and Cervix, uterus and breast in female reflecting the potential lifestyle and environmental factors.

Elango. J K et al (2009) conducted a study on factors affecting oral cancer awareness in a high risk population in India. The study reveals that forty percent (40%) of males and 14% females had one or more high risk habits. It was observed that awareness was proportioned to the educational level and inversely proportional to the prevalence of risk factor habits. 82% of the smokers, 75% of the tobacco chewers and 66% of those who consume alcohol were aware that their habits could lead to oral cancer. Overall, the awareness of oral cancer in this high-risk population was satisfactory, though certain gaps exist, pointing to a need for targeted health education and risk factor cessation counseling.

Patel J B et al (2009) did a study on the role of nitric oxide and antioxidant enzymes in the pathogenesis of oral cancer. Oral cancer is the leading malignancy in India. The study showed that the alterations in antioxidant activities were associated with the production of nitric oxide in oral cancer, which may have a significant role in oral carcinogenesis.

Sharma G et al (2009) did a study on oral manifestations as predictors of immune suppression in an HIV-/AIDS – infected population in south India. This study revealed that concurrent manifestations were good predictors of severe immune suppression. In most resource poor countries where facilities for undertaking CD4+ counts are not available, the presence of concurrent oral manifestations may be used as an indicator of deteriorating immune system.

Dagli R J et al (2008) did a study on prevalence of leukoplakia, oral sub mucous fibrosis, papilloma and its relation with stress among green marbles mine laborer, India. The evidence shows that an overall elevated prevalence of oral mucosal lesion was found among (36.7%)

mine workers, leukoplakia among (33.3%). The study concluded that occupational stresses can intensify the disease condition.

Rai B et al (2007) did a study on salivary vitamin E and C in oral cancer. In this study levels of antioxidant vitamins E and C were estimated in 50 patients with oral cancer and 24 healthy persons served as control. Significantly lower levels of vitamin E and C were observed in oral cancer patients as compared to controls. Antioxidant nutrients may be utilized to a greater extent in oral cancer patients to counteract free radical- mediated cell disturbances, resulting in a reduction in salivary antioxidant levels.

Saraswathi T R et al (2006) did a cross sectional study in South India about the prevalence of oral lesions in relation to habits. Oral soft tissue lesions were found in 4% of the study subjects. The prevalence of leukoplakia, OSF and oral lichen planus was 0.59%, 0.55% and 0.15% respectively. The prevalence of smoking, drinking alcoholic beverages and chewing was 15.02%, 8.78% and 6.99% respectively. Smoking and chewing were significant predictors of leukoplakia in this population.

CHAPTER- III
RESEARCH METHODOLOGY

This chapter comprises the methodology for the study, the research approach, and design of the study, study settings, sample size, sampling technique of data collection, the pilot study and plan for analysis of the data. The study was done to determine the effectiveness of the video assisted teachingof knowledge regarding the prevention of oral cancer among people residing at Manamadurai block.

RESEARCH APPROACH

The quantitative approach was used for this study.

RESEARCH DESIGN

One group pre test, post test design was used in this study. In this design the researcher conducted one pretest for the selected samples then gives video assisted teaching and conducts post test for the same samples.

01X02

01 – Pretest assessment on knowledge regarding the prevention of oral cancer.

02 – Post test assessment of knowledge regarding prevention of oral cancer.

X – (Video assisted teaching on knowledge regarding the prevention of oral cancer).

SETTING OF THE STUDY

The study was conducted in selected areas in and around Manamadurai. Manamadurai was selected because of the availability of subjects and feasibility of conducting the study. The study was conducted in milaganoor and Manamadurai town.

In Milaganoor the total population is 1370 among this male were 686, female were 684. Alcohol and betel chewing were found common among this population. So the research conducted the study in this area

POPULATION

It refers to the entire aggregation of samples that meet the designated criteria.

SAMPLE

Samples in the age group of above 18 years who are residing in Manamadurai block.

SAMPLE SIZE

In this study 100 samples were selected who fulfilled the inclusion criteria.

SAMPLING TECHNIQUE

In this study, the samples were selected by purposive sampling technique.

CRITERIA FOR SAMPLE SELECTION

INCLUSION CRITERIA

- Samples who are permanently residing Manamadurai block.
- Samples include both male and female above 18 years of age.
- Samples who can read or understand Tamil.
- Patient with medical and surgical illness also included.

EXCLUSION CRITERIA

- Samples those are not willing to participate in the study.
- Temporary residents' (friends, relatives, business personals) at Manamadurai block.
- Patients who have been diagnosed to have other types of cancer.

DESCRIPTION OF TOOL

The final tool consists of two sections,

Section A: Demographic data

Section B: Multiple choice questions on knowledge regarding prevention of oral cancer.

SECTION A: (demographic data)

It deals with background information. Items included were age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

SECTION B

It is a self developed multiple choice questionnaire which consists of questions on the knowledge regarding the prevention of oral cancer. It has 25 questions with four options. Among the four options three are distracters and one correct answer.

SCORING PROCEDURE

Total items are 25. Each question has four options in which 3 are distracted and one is the correct answer. Correct answer carries the score of one and distracters carries zero score. Maximum score was 25 and minimum score was 0 and the total score is 25.

By applying statistical formula, the level of knowledge is categorized as follows:

Level of knowledge	Score
Adequate level of knowledge	23 and above
Moderately adequate knowledge	14 to 22
Inadequate level of knowledge	13 and below

TESTING OF THE TOOL

VALIDITY

In order to ensure the content validity, the tool and video teaching program was submitted to five experts in the field of medicine and nursing. After establishing the validity, the tool was translated intoTamil and again in English to validate the language.

RELIABILITY

The reliability of the tool was obtained by establishing the test-retest method.

PILOT STUDY

Before conducting a pilot study, the formal consent was obtained from the Panchayat president, Manamadurai block. 10 samples were selected those who fulfilled the criteria. The existing knowledge was assessed and video assisted teaching was followed by pre test. Post test was done after two weeks. The results were analyzed based on the scores obtained from the samples and computed with inferential statistics. These samples were excluded from the final study.

DATA COLLECTION PROCEDURE

The data were collected for a period of 6 weeks. Data was collected from Monday to Saturday. The time schedule for data collection extends from 8am to 4pm in Manamadurai. Permission was obtained from the Matha College of Nursing, Dissertation committee and from the Panchayat president and chief medical officer at government hospital Manamadurai.

100 samples that fulfilled the inclusion criteria were taken for consideration. Time spent on each sample was around 30 minutes. 4 samples were selected per day. The researcher got consent and willingness from the selected samples. The researcher first assessed the existing level of knowledge and video assisted teaching wasgiven for forty five minutes. On the completion of the teaching program each one was given time to clarify their doubts and ask questions post test was conducted after two weeks with the same questionnaire.

DATA ANLYSIS

The data analysis was done according to the objectives of the study. Both descriptive and inferential statistics were used.

Descriptive statistics

Frequency, percentage and mean were used for analysis of pre test and post test assessments.

Inferential statistics

The paired ‘t’ test was used to determine the difference between pretest and post test levels of knowledge.

PROTECTION OF HUMAN RIGHTS

The dissertation committee approved the research proposal prior toPilot study and for the main study permission was obtained from the head of the department of medical surgical Nursing, Matha College of Nursing, Manamadurai, and from the hospital and local administration body. Verbal consent was obtained from the study subjects and the data collection was kept as confidential. Assurance was given to the study subjects that anonymity of each individual would be maintained.

CHAPTER – IV

ANALYSIS AND INTERPRETATION OF DATA

This chapter presents the analysis and interpretation of data collected from the samples to determine the effectiveness of the video assisted teaching on knowledge regarding the prevention of oral cancer. A quantitative approach was used for the present study. The analysis was done in order to achieve the following objectives of the study.

The objectives of the study are

1. To assess the existing level of knowledge onthe prevention of oral cancer among the rural population.
2. To evaluate the effectiveness of video assisted teaching in terms of improving knowledge on the prevention of oral cancer among the rural population.
3. To find out the association with the posttest level of knowledge on the prevention of oral cancer and their selected demographic variables such as client age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

During the data analysis, the data were reduced to an interpretable form to summarize the findings, test the hypothesis and establish the relationship between the variables.

ORGANIZATION OF THE STUDY FINDINGS

Section I: Distribution of samples according to their demographic variables.

Section II: Distribution of samples according to level of knowledge before and after video assisted teaching.

Section III: Effectiveness of video assisted teaching in improving knowledge on the prevention of oral cancer.

Section IV: Association between post test level of knowledge and selected demographic variables such as client age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

SECTION I

Table1: Distribution of the samples according to their demographic variables.

[n=100]

S. No	Demographic variable	No of subjects	
		Frequency	Percentage (%)
1	**Age in years**		
	a. 18-25years	27	27.0
	b. 26-35 years	25	25.0
	c. 36-45 years	25	25.0
	d. 45 years and above	23	23.0
2	**Sex**		
	a. Male	55	55.0
	b. Female	45	45.0
3	**Religion**		
	a. Hindu	44	44.0
	b. Christian	35	35.0
	c. Muslim	21	21.0
4	**Place of residence**		
	a. Urban	66	66.0
	b. Rural	34	34.0
5	**Marital status**		
	a. Married	63	63.0
	b. Unmarried	24	24.0
	c. Widow	7	7.0
	d. Divorce	6	6.0

S. No	Demographic variable	No of subjects	
		Frequency	Percentage (%)
6	**Number of children's in the family**		
	a. One	29	29.0
	b. Two	13	13.0
	c. Three	30	30.0
	d. Four and above	28	28.0
7	**Type of family**		
	a. Nuclear family	39	39.0
	b. Joint family	61	61.0
8	**Education**		
	a. Illiterate	11	11.0
	b. Primary school	15	15.0
	c. Higher secondary education	47	47.0
	d. Degree holder	27	27.0
9	**Occupation**		
	a. Unemployment	11	11.0
	b. Cooley	18	18.0
	c. Government employee	31	31.0
	d. Private employee	24	24.0
	e. Self employment	16	16.0
10	**Monthly income**		
	a. Less than Rs 1000	9	9.0
	b. Rs 1001-3000	23	23.0
	c. Rs 3001-5000	32	32.0
	d. 5001and above	36	36.0

S. No	Demographic variable	No of subjects	
		Frequency	Percentage (%)
11	**Dietary pattern**		
	a. Vegetarian	15	15.0
	b. Non-vegetarian	16	16.0
	c. Mixed	69	69.0
12	**Habit**		
	a. Liquor	15	15.0
	b. Beetal leaves	14	14.0
	c. Smoking	20	20.0
	d. None	51	51.0
13	**Recreation**		
	a. Cinema	30	30.0
	b. Music	19	19.0
	c. Reading	15	15.0
	d. Conversation	20	20.0
	e. None	16	16.0
14	**Exposure to Mass Media**		
	a. Television	17	17.0
	b. News paper	15	15.0
	c. Advertisement	12	12.0
	d. Radio	11	11.0
	e. All the above	45	45.0

S. No	Demographic variable	No of subjects	
		Frequency	percentage
15	**Family History of cancer**		
	a. Yes	18	18.0
	b. No	82	82.0
16	**Exposure to radiation**		
	a. yes	19	19.0
	b. no	81	81.0

The table-1 shows the frequency & percentage of demographic variables such as age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

The age group of rural population selected for the study was divided into 4 groups, 27 [27%] were between18-25 years, 25 [25%] were between 26-35 years, 25 [25%] were between 36-45 years, 23 [23%] were above 46 years.

Regarding sex of the sample group 55 [55%] were males, 45 [45%] were females.

With regard to religion of sample group 44 [44%] were Hindu, 35 [35%] were Christian and 21 [21%] were Muslim.

With regard to place of residence 66 [6%] were rural and 34 [34%] were urban.

With regard tomarital status 63 [63%] were married, 24 [24%] were unmarried, 7 [7%] were widows and 6 [6%] divorced.

With regard to no of children of the subjects 29 [29%] hadone child, 13 [13%] had two children, 30 [30%] had more than two children, 28 [28%] had no children.

Regarding the type of family 39 [39%] werefrom nuclear family, 61 [61%] were from joint family.

Regarding the educational status of the subjects 11 [11%] were illiterates, 15 [15%] had primary education, 47 [47%] had higher secondary education, 27 [27%] had a degree and above.

Regarding monthly income of the family 9 [9%] were getting Rs- below 1000, 23 [23%] were getting Rs- 1001-3000, 32 [32%] were getting Rs-3001-5000, 36 [36%] were getting above Rs 5000

Regarding dietary pattern 15 [15%] were vegetarian, 16 [16%] were non vegetarian, 69 [69%] were taking mixed diet.

Regarding personal habits of the subjects 15 [15%] liquor, 14 [14%] have the habit of chewing betel leaves, 20 [20%] were smoked, 51 [51%] have no such habits.

Regarding recreation 30 [30%] clients watch movies, 19 [19%] clients hear music, 15 [15%] read, 20 [20%] converse with others, 16 [16%] has no such habits.

Regarding the influence of communication media 17 [17%] clients watch television 15 [15%] read newspaper, 12 [12%] read posters, 11 [11%] listen to radio, 45 [45%] influence through all the above media.

Regarding family history of cancer 18 [18%] has the family history of cancer, 82 [82%] had no family history of cancer.

Regarding history of exposure to radiation 19 [19%] had frequent exposure to radiation, 81 [81%] had no exposure to radiation.

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Fig-2. Distribution of samples according to Age in years

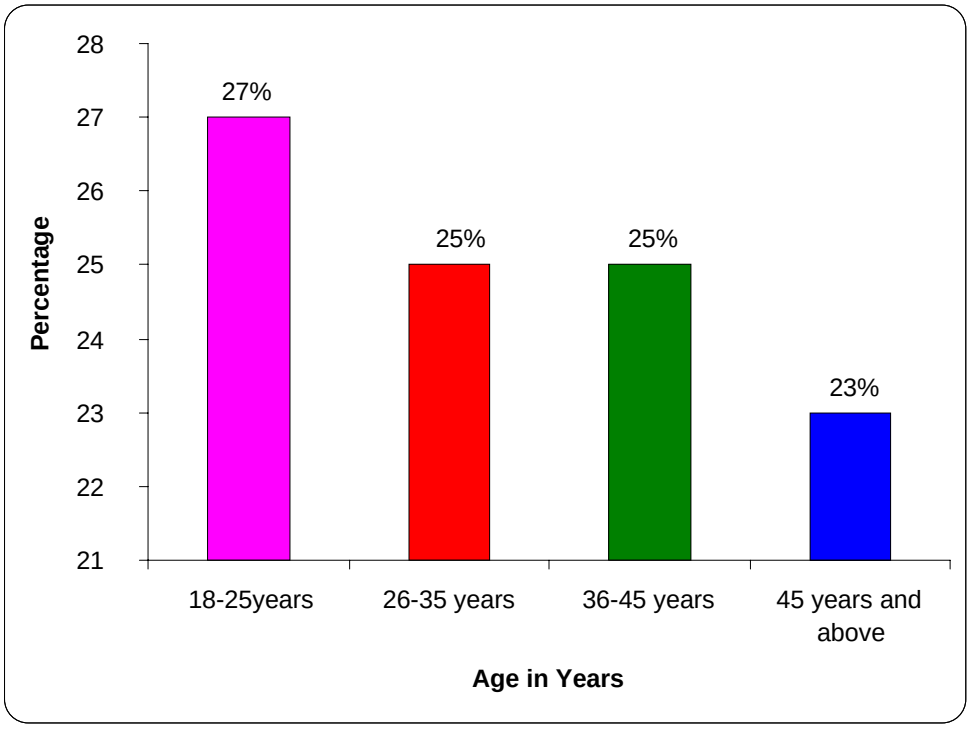


Fig-3. Distribution of samples according to Sex

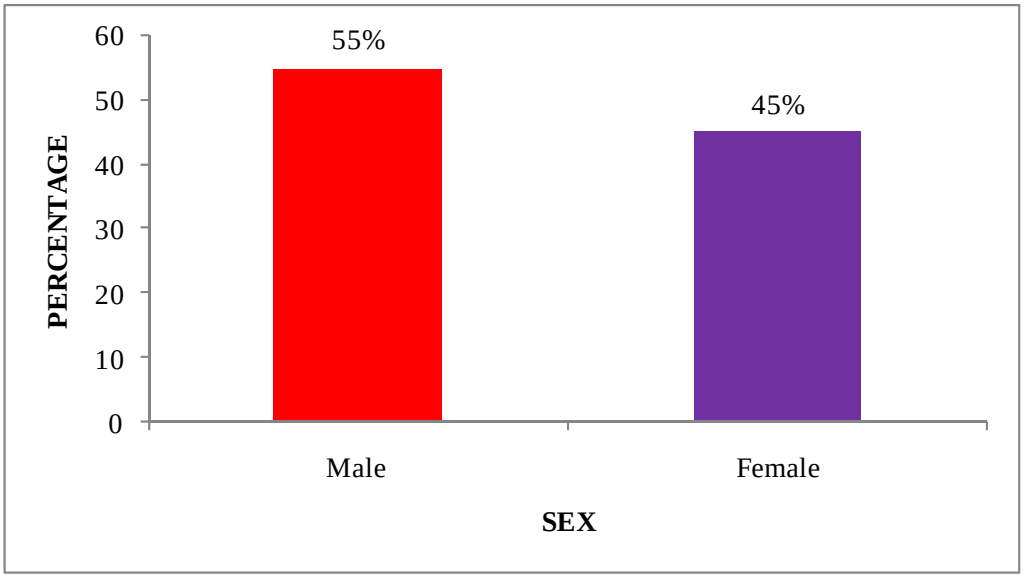


Fig-4. Distribution of samples according to Religion

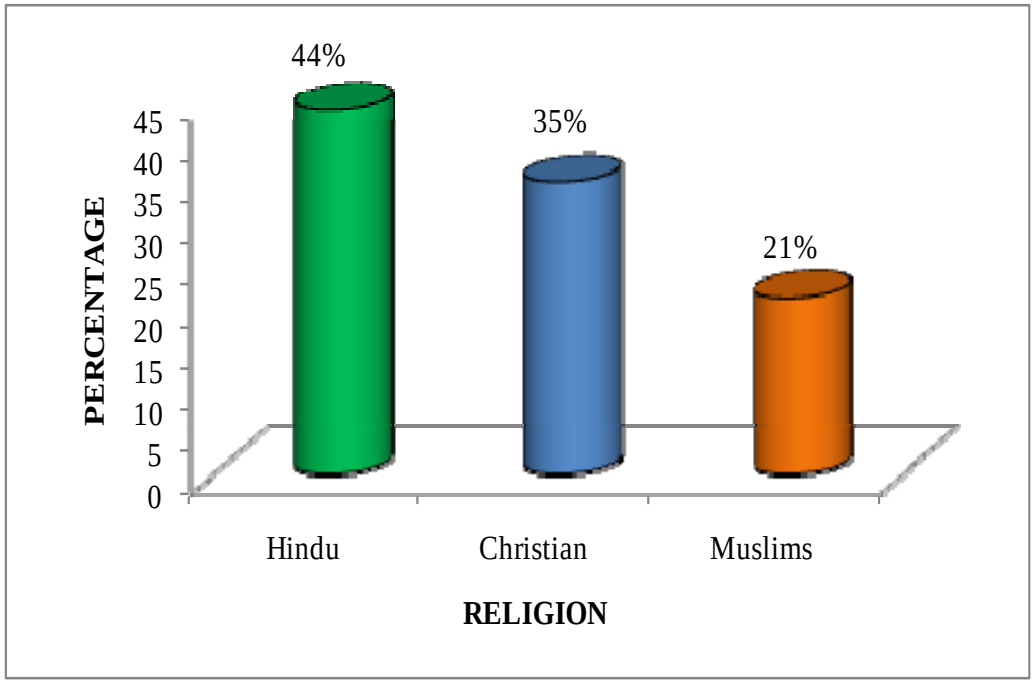


Fig-5. Distribution of samples according to Place of residence

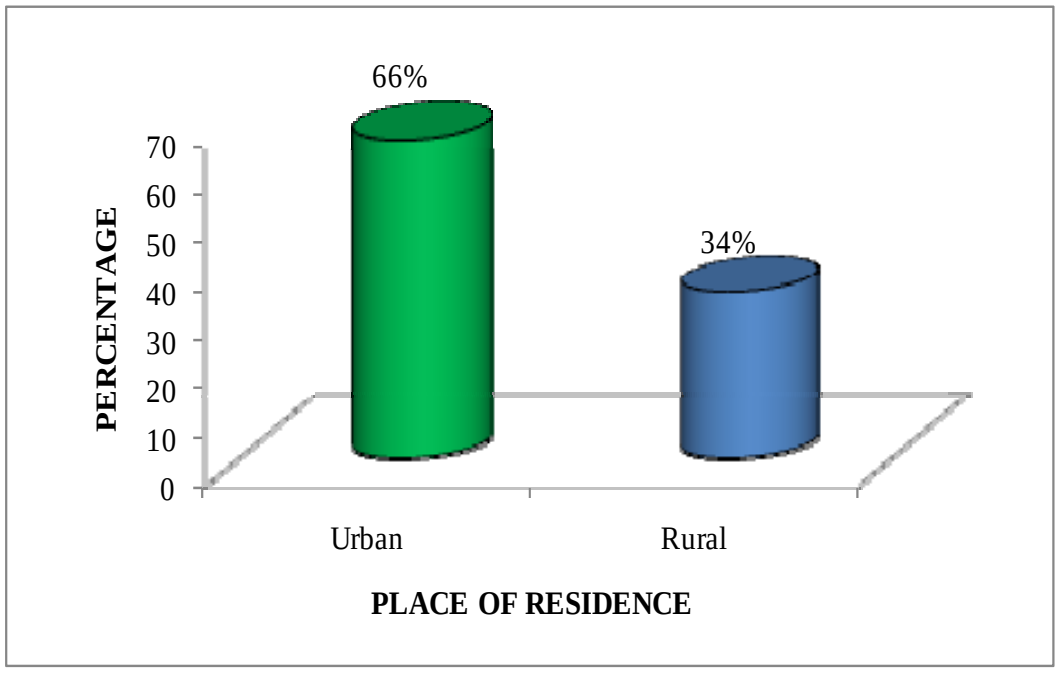


Fig-6. Distribution of samples according to Marital status

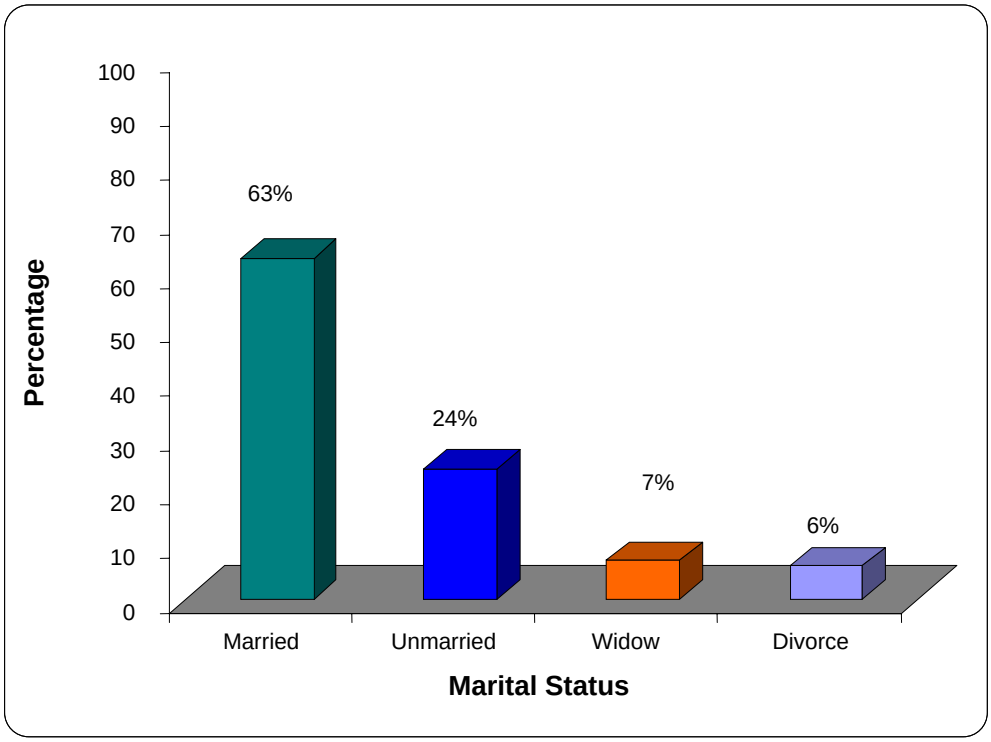


Fig-7. Distribution of samples according to Number of children

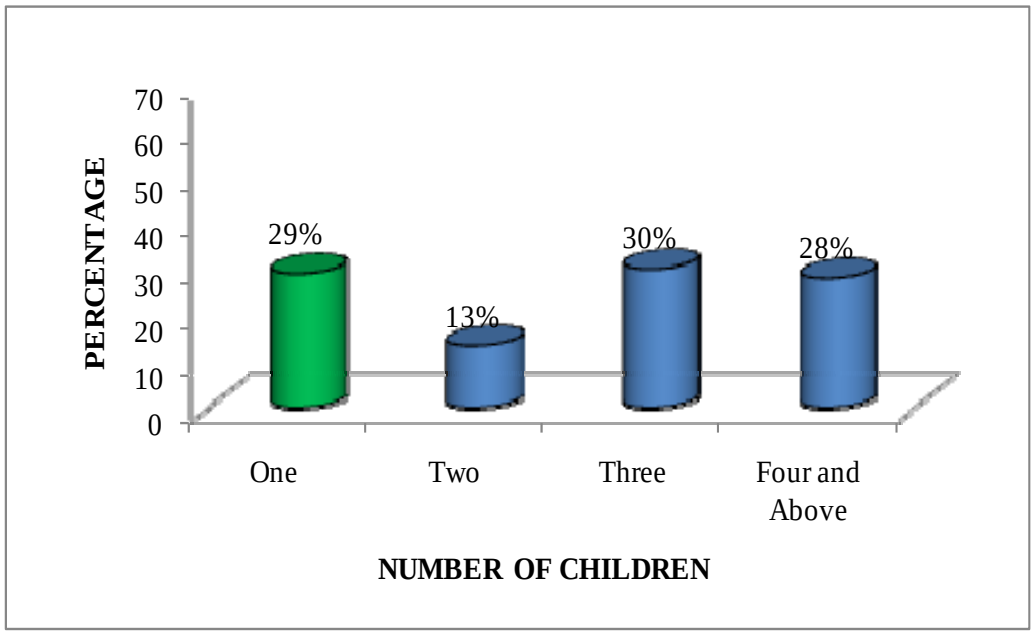


Fig-8. Distribution of samples according to type of family

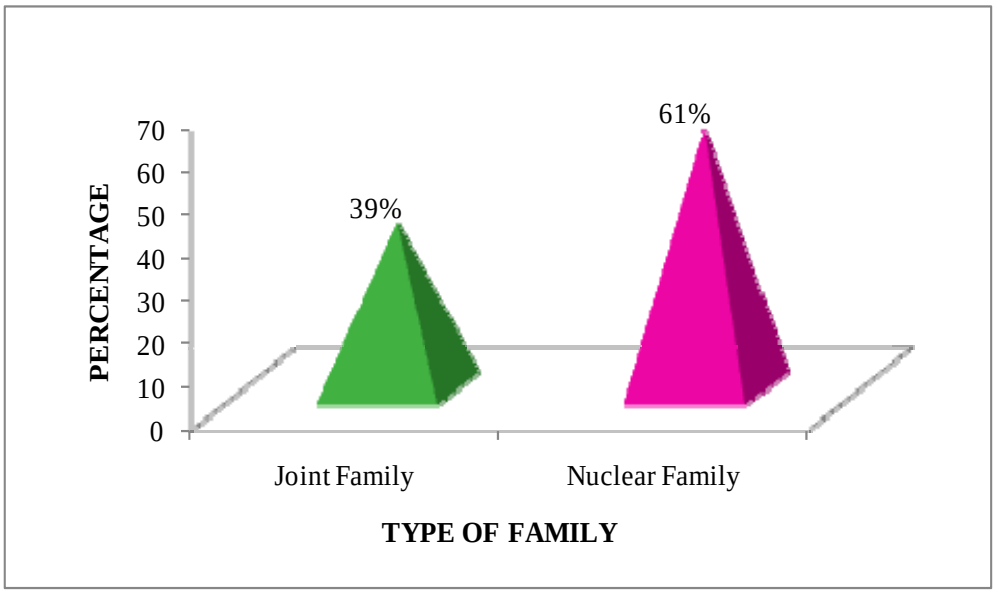


Fig-9. Distribution of samples according to Education

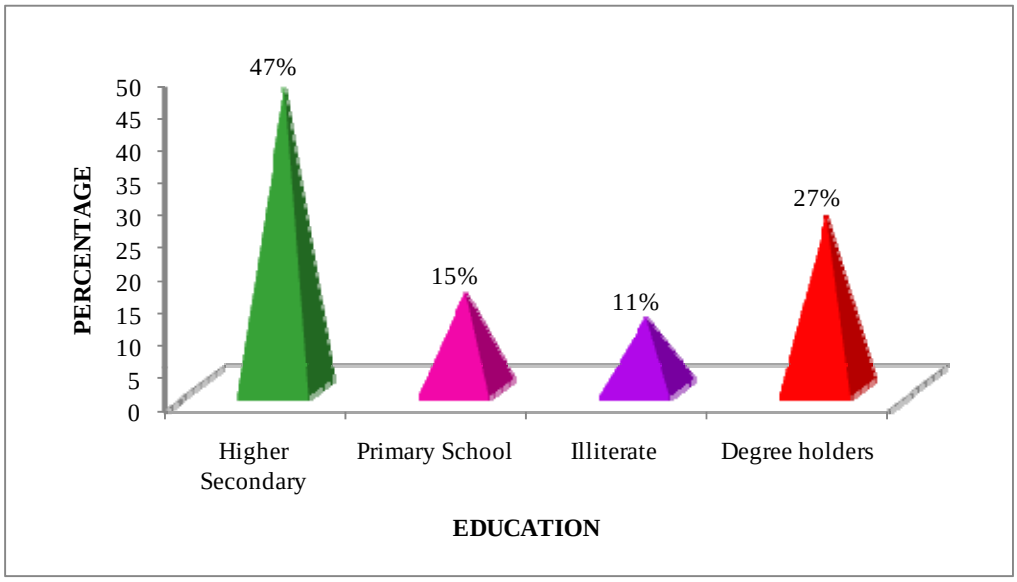


Fig-10. Distribution of samples according to Occupation

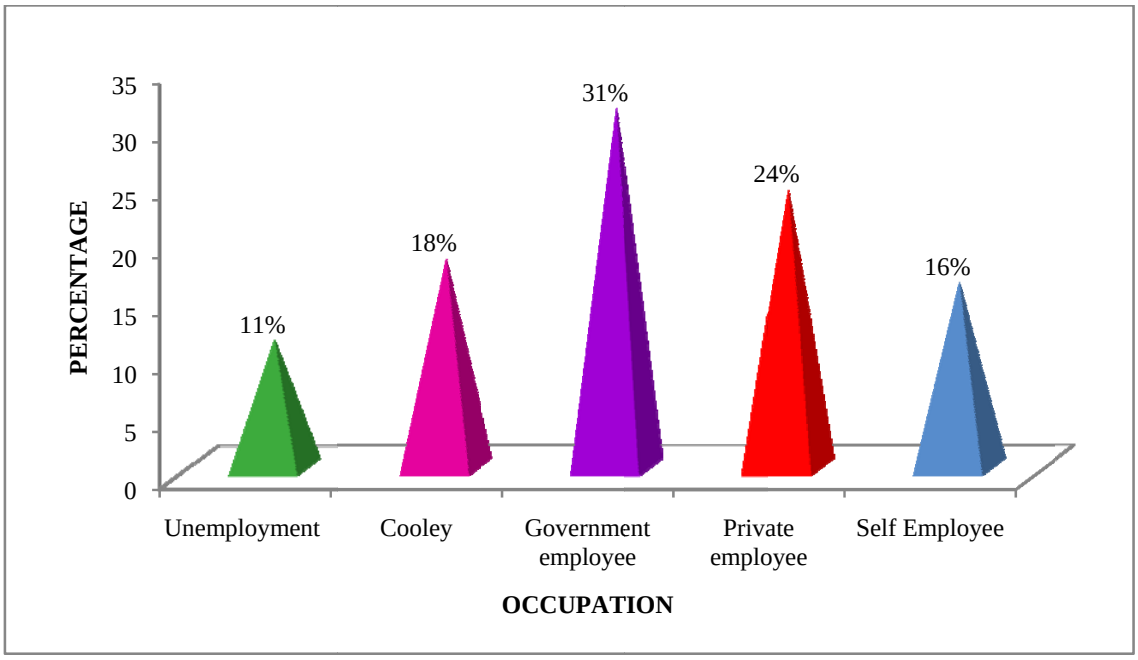


Fig-11. Distribution of samples according to Monthly income

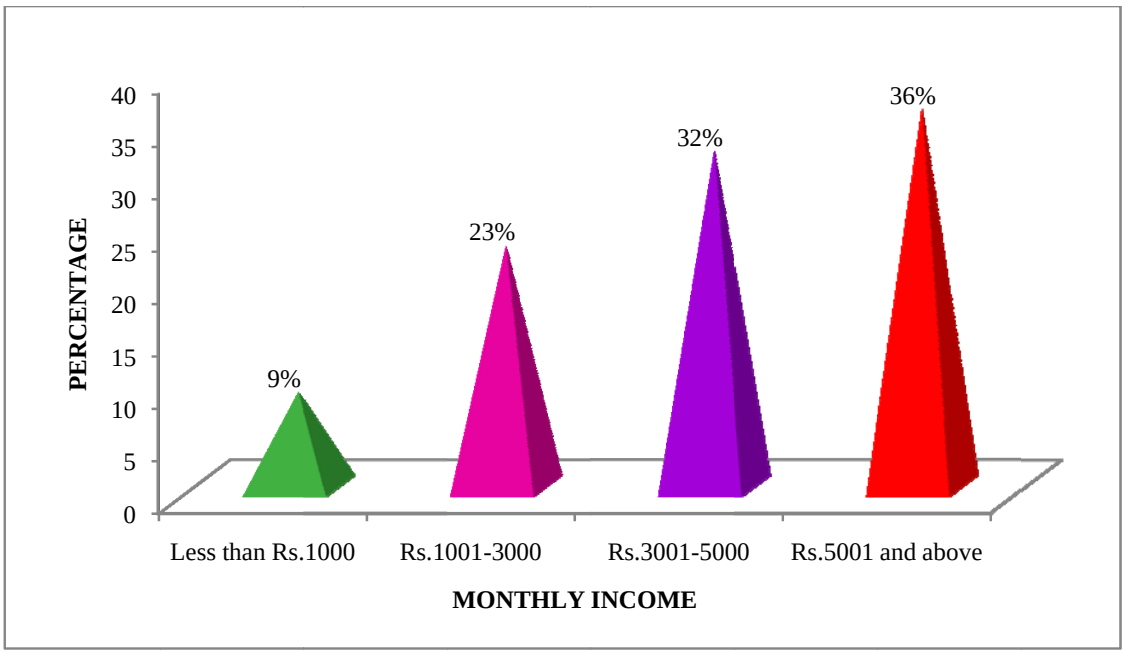


Fig-12. Distribution of samples according to Dietary pattern

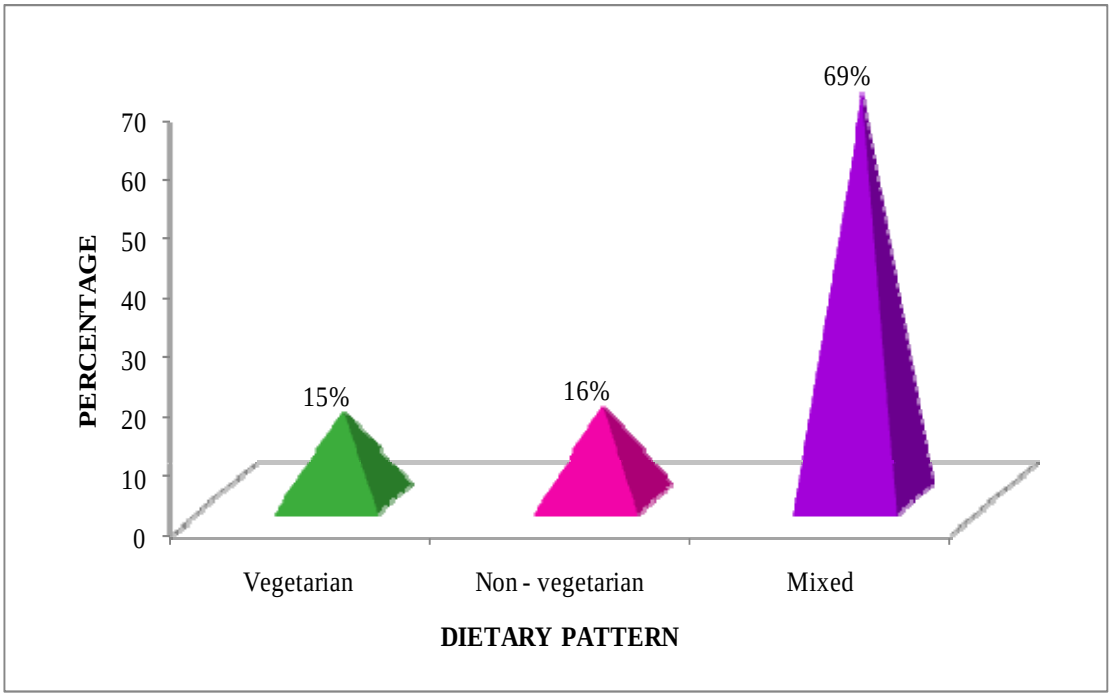


Fig-13. Distribution of samples according to Habit

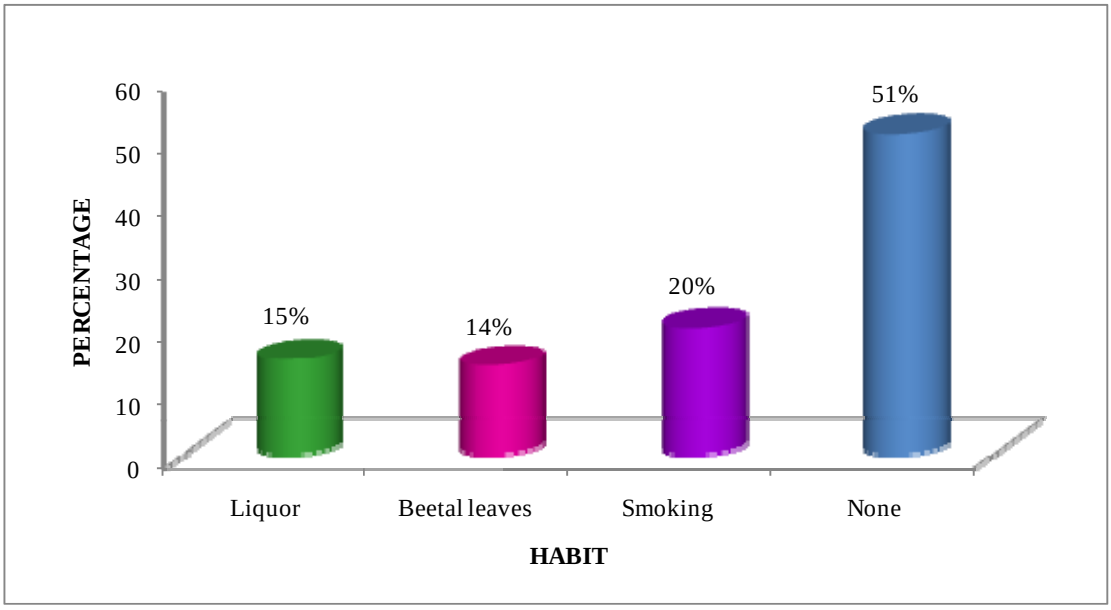


Fig-14. Distribution of samples according to Recreation

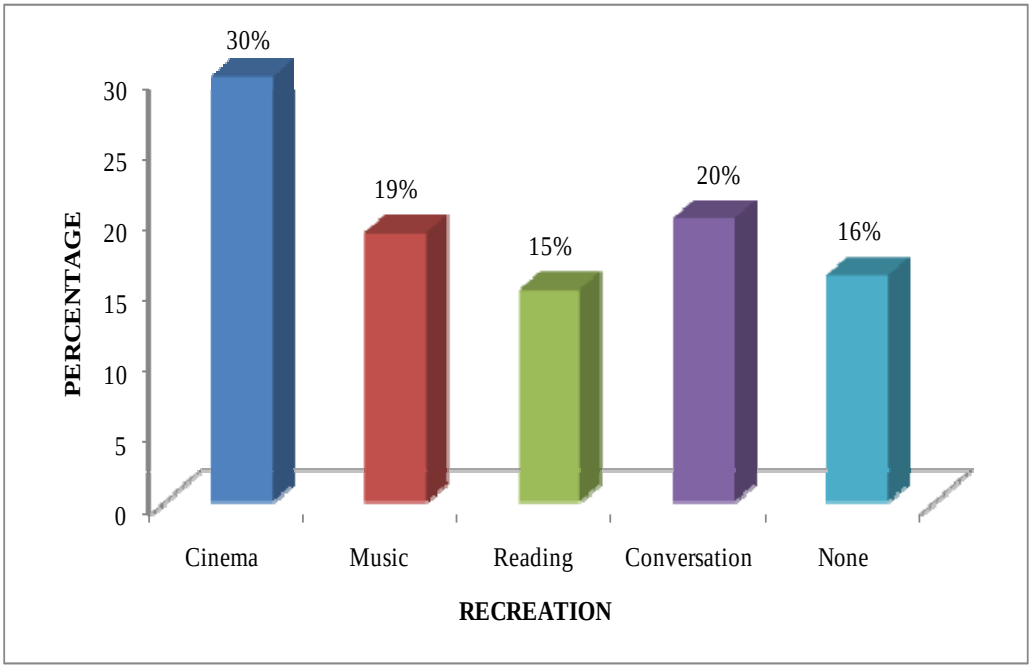


Fig-15. Distribution of samples according to exposure to Media

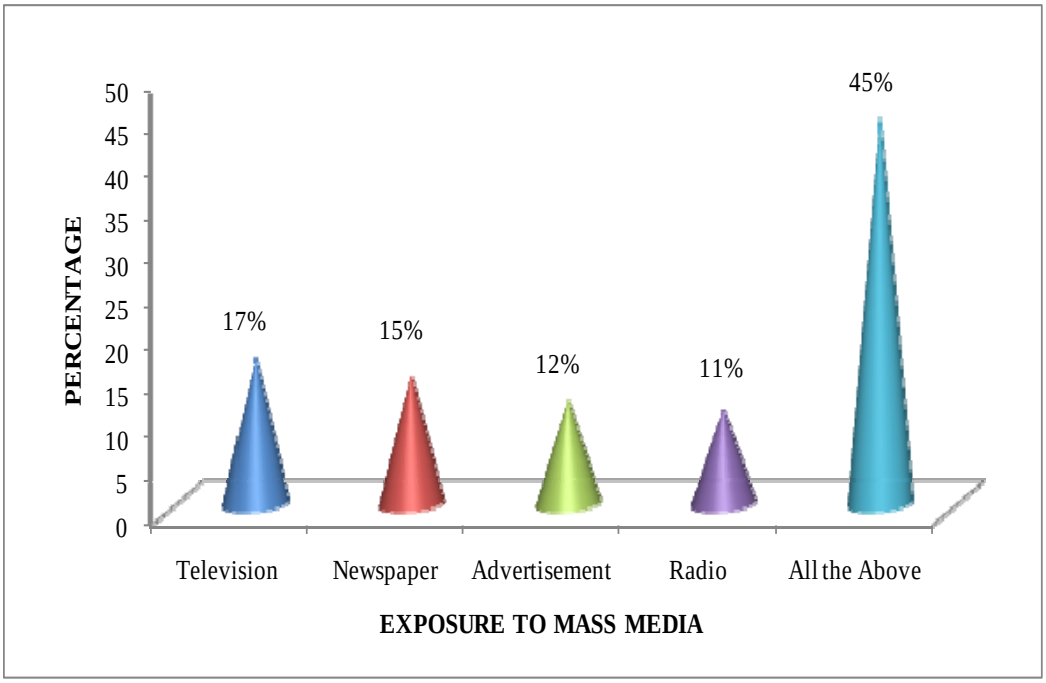


Fig-16. Distribution of samples according to Family history of cancer

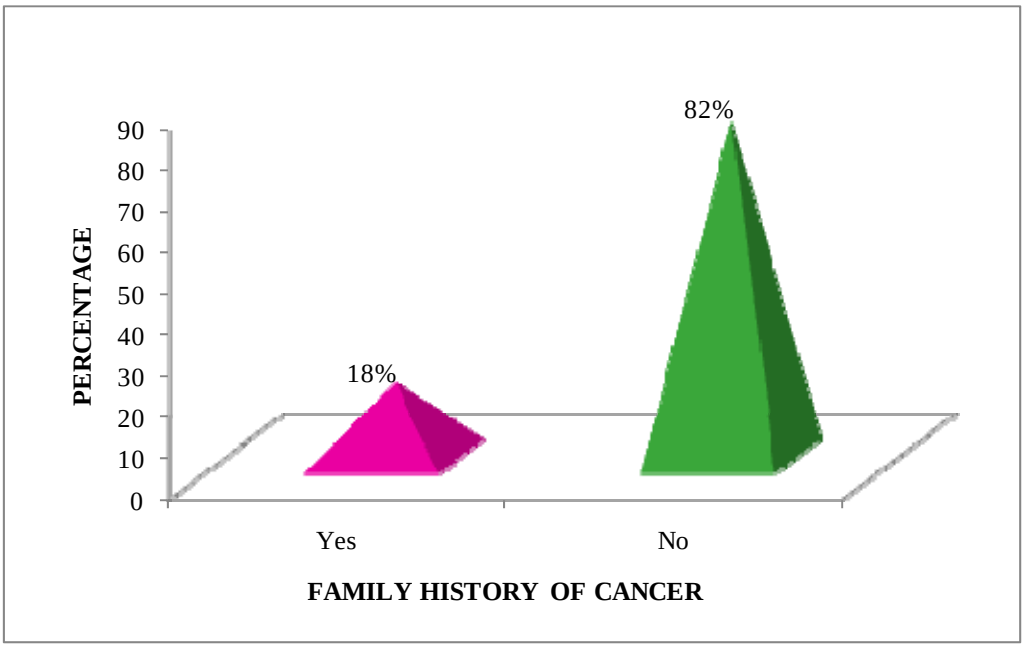
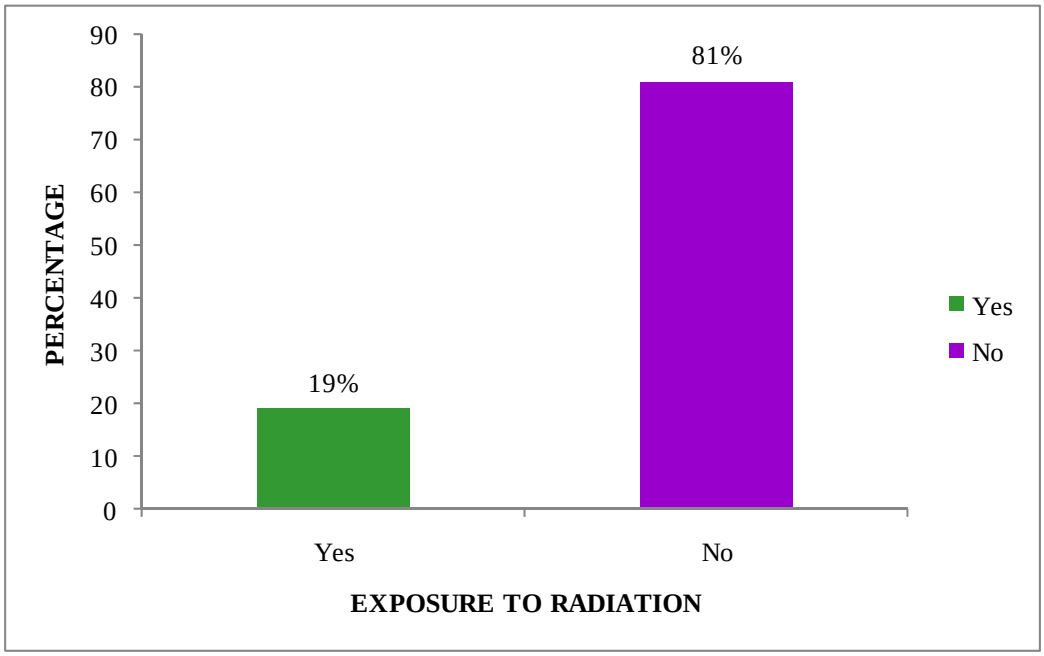


Fig-17. Distribution of samples according to Exposure to radiation



SECTION II

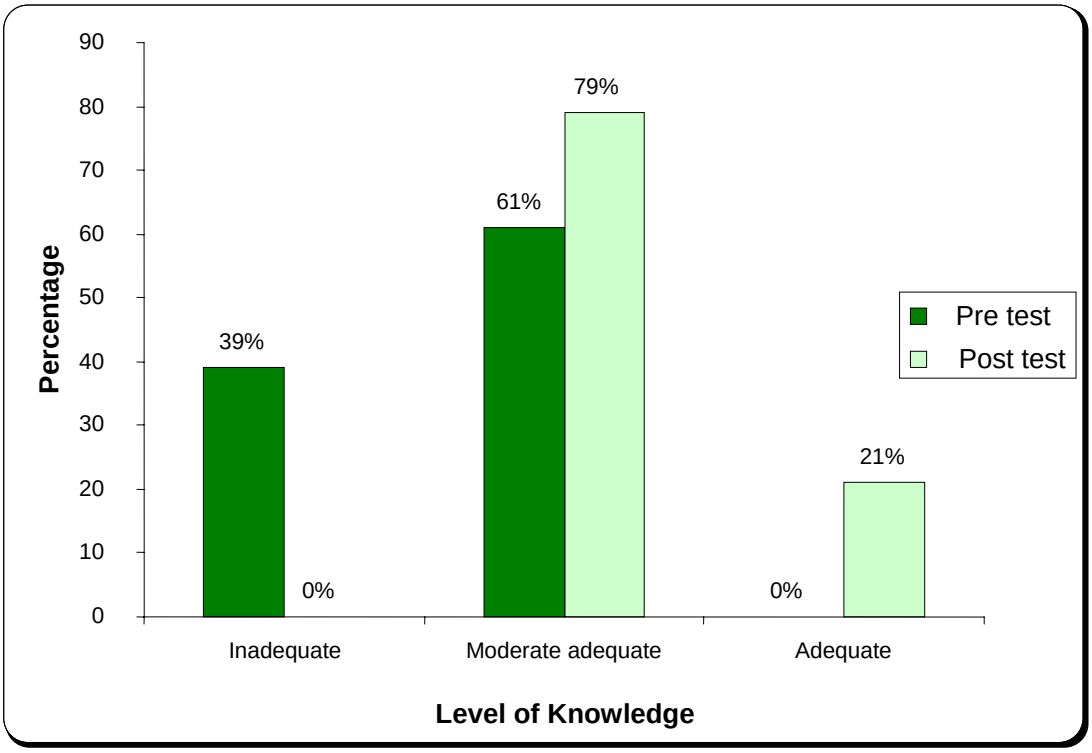
Table: 2 Distribution of samples according to level of knowledge before and after intervention.

(n=100)

Sl .No	Level of knowledge	Pre test		Post test	
		f	%	f	%
1.	Inadequate	39	39.0	-	-
2.	Moderate adequate	61	61.0	79	79.0
3.	Adequate	-	-	21	21.0

The above table shows that pretest among the subjects, 39 [39%] were inadequate level of knowledge, 61 [61%] were moderate level of knowledge and none of them having an adequate level of knowledge regarding the prevention of oral cancer. In post test among the subjects, 79 [79%] were moderate level of knowledge and 21 [21%] had an adequate level of knowledge regarding the prevention of oral cancer.

Fig-18. Distribution of samples according to level of knowledge of Pre test and Post test



SECTION III

Effectiveness of video assisted teaching in improving knowledge on the prevention of oral cancer.

Table: 3 mean pretest and post test knowledge level.

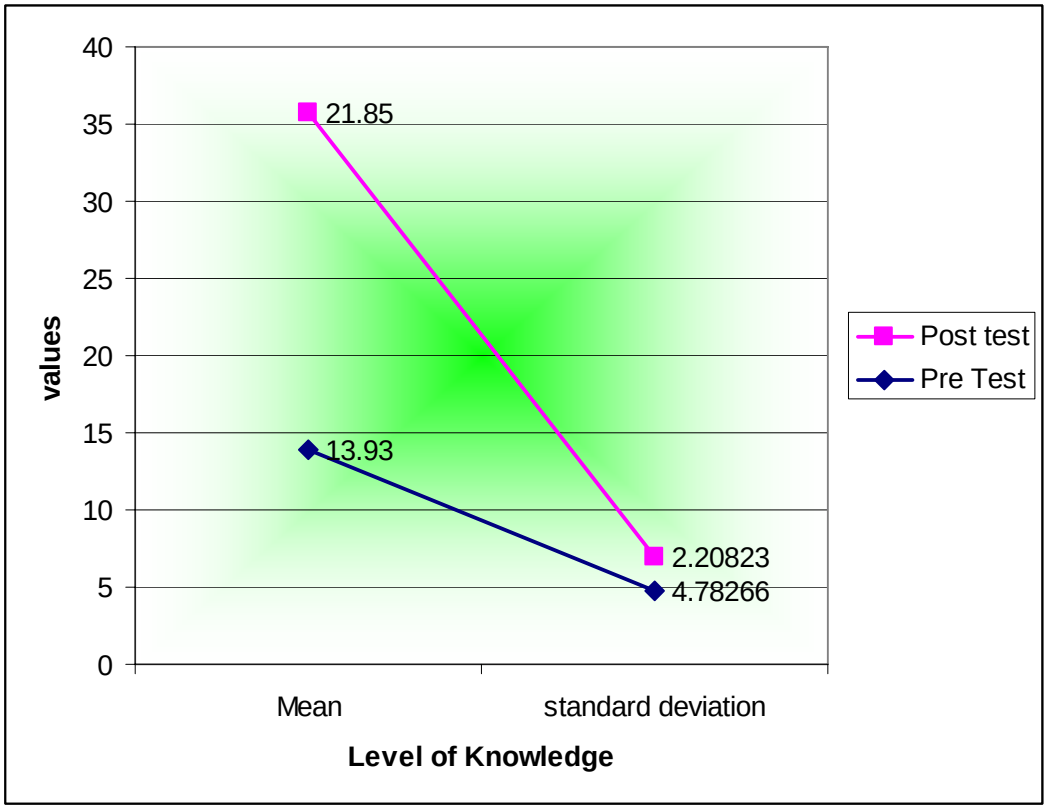
(n=100)

Si. no	Level of knowledge	Mean	standard deviation	t value
1.	Before intervention	13.9300	4.78266	17.273*
2.	After intervention	21.8500	2.20823	

***- Significant at 0.05 levels**

Mean score on level of knowledge regarding prevention of oral cancer was21. 8500 in post test which is significantly higher than, 13.9300 in pre test and computed value of t' is 17.273 is more than the table value [1.984] at DF [99] which is statistically significant at 0.05 levels. This data shows that video assisted teaching was effective in improving the knowledge regarding oral cancer.

Fig-19.Mean and Standard Deviation of pretest and post test knowledge level.



SECTION IV

Table: 4 Association between post test level of knowledge and their selected demographic variables

[n=100]

Sl. no	Demographic variables	level of knowledge						table value	chi-square value
		In-adequate		Moderately adequate		Adequate			
		f	%	f	%	f	%		
1.	Age								
	• 18-25years	-	-	24	24.0	3	3.0		
	• 26-36years	-	-	21	21.0	4	4.0		
	• 36-45 years	-	-	18	18.0	7	7.0	7.82	3.941
	• 45 years and above	-	-	16	16.0	7	7.0		
2.	Sex								
	• Male	-	-	44	44.0	11	11.0	3.84	0.074
	• Female	-	-	35	35.0	10	10.0		
3.	Religion								
	• Hindu	-	-	33	33.0	11	11.0		
	• Christian	-	-	28	28.0	7	7.0	5.99	1.016
	• Muslim	-	-	18	18.0	3	3.0		
4.	**Area of residence**								
	• Rural	-	-	52	52.0	14	14.0	3.84	0.005
	• Urban	-	-	27	27.0	7	7.0		

Sl. no	Demographic variables	level of knowledge						table value	chi-square value
		In-adequate		Moderately adequate		Adequate			
		f	%	f	%	f	%		
5.	**Marital status**								
	• Married	-	-	48	48.0	15	15.0		
	• Unmarried	-	-	20	20.0	4	4.0	7.82	
	• Widow	-	-	7	7.0	-	-		2.982
	• Divorce	-	-	4	4.0	2	2.0		
6.	**Number of children's in the family**								
	• One	-	-	21	21.0	8	8.0		
	• Two	-	-	11	11.0	2	2.0	7.82	
	• Three	-	-	25	25.0	5	5.0		1.384
	• Four and above	-	-	22	22.0	6	6.0		
7.	**Type of family**								
	• Nuclear family	-	-	30	30.0	9	9.0		0.166
	• Joint family	-	-	49	49.9	12	12.0	3.84	
8.	**Education**								
	• Illiterate	-	-	19	19.0	1	1.o		
	• middle school	-	-	24	24.0	2	2.0	7.82	67.750
	• Higher secondary	-	-	36	36.0	5	5.0		*
	• Degree holder	-	-	-	-	15	15.0		
9.	**Occupation**								
	• Unemployment	-	-	10	10.0	1	1.0		
	• Cooley	-	-	15	15.0	3	3.0		
	• Govt. servant	-	-	25	25.0	6	6.0	9.49	2.439
	• Private employee	-	-	18	18.0	6	6.0		
	• Self employment	-	-	11	11.0	5	5.0		

Sl. no	Demographic variables	level of knowledge						table value	chi-square value
		In-adequate		Moderately adequate		Adequate			
		f	%	f	%	f	%		
10	**Monthly income**								
	• Less than Rs 1000	-	-	8	8.0	1	1.0		
	• Rs 1001-3000	-	-	19	19.0	4	4.0	7.82	1.806
	• Rs 3001-5000	-	-	26	26.0	6	6.0		
	• 5001and above	-	-	26	26.0	10	10.0		
11	**Dietary pattern**								
	• Vegetarian	-	-	10	10.0	5	5.0		
	• Non-vegetarian	-	-	13	13.0	3	3.0	7.82	1.618
	• Both veg and non-veg	-	-	56	56.0	13	13.0		
12	**Habit**								
	• Liquor	-	-	30	30.0	1	1.0		
	• Beetal leaves	-	-	32	32.0	-	-	7.82	60.186
	• Smoking	-	-	14	14.0	4	4.0		*
	• None	-	-	3	3.0	16	16.0		
13	**Recreation**								
	• Cinema	-	-	26	26.0	4	4.0		
	• Music	-	-	16	16.0	3	3.0	9.49	3.096
	• Redding	-	-	10	10.0	5	5.0		
	• Conversation	-	-	15	15.0	5	5.0		
	• None	-	-	12	12.0	4	4.0		

Sl. no	Demographic variables	level of knowledge						table value	chi-square value
		In-adequate		Moderately adequate		Adequate			
		f	%	f	%	f	%		
14	**Mass Media**								
	• Television	-	-	14	14.0	3	3.0		
	• News paper	-	-	12	1.0	3	3.0		
	• Advertisement	-	-	10	10.0	2	2.0	9.49	0.635
	• Radio	-	-	9	9.0	2	2.0		
	• All the above	-	-	34	34.0	11	11.0		
15	**family history of cancer**								
	• Yes	-	-	14	14.0	4	4.0	3.84	
	• No	-	-	65	65.0	17	17.0		0.020
16	**Exposure to radiation**								
	• Yes	-	-	16	16.0	13	13.0	3.84	0384
	• No	-	-	63	63.0	18	18.0		

***- significant at 0.05 levels**

The hypothesis states that there is an association between post test level of knowledge and their selected demographic variables. In the table the chi square value shows that the calculated value is higher than the table value for education and habits. So the researcher concluded that there is a significant association between post test level of knowledge and demographic variables such as education and habits.

CHAPTER-V

RESULT AND DISCUSSION

The present study is designed to determine the effectiveness of video assisted teaching in terms of improving knowledge regarding the prevention of oral cancer.

A quantitative approach was used for the study. A purposive sampling was done to select samples. The data collection tools were used to bring out the relevant history.

The major findings of the study are discussed in light of the formulated objectives, which are as follows:

OBJECTIVES

- To assess the existing level of knowledge on the prevention of oral cancer among the rural population.
- To evaluate the effectiveness of video assisted teaching in terms of improving knowledge on the prevention of oral cancer among the rural population.
- To find out the association between the post test level of knowledge on the prevention of oral cancer and their selected demographic variables such as age, sex, education, occupation, dietary pattern, type of family, habits, recreation,family history of cancer,exposure to media.

FINDINGS OF THE STUDY

Demographic distribution of the samples

The table-1 shows the frequency & percentage of demographic variables such as age of the client age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, diet, habits, recreation, communication, family history of cancer and exposure to radiation.

The age group of rural population selected for the study was divided into 4 groups, 27 [27%] were between18-25 years, 25 [25%] were between 26-35 years, 25 [25%] were between 36-45 years, 23 [23%] were above 46 years.

Regarding sex of the sample 55 [55%] were males, 45 [45%] were females.

With regard to religion of sample 44 [44%] were Hindu, 35 [35%] were Christian and 21 [21%] were Muslim.

With regard to place of residence 66 [6%] were rural and 34 [34%] were urban.

With regard to marital status 63 [63%] were married, 24 [24%] were unmarried, 7 [7%] were widows and 6 [6%] divorced.

With regard to no of children of the subjects 29 [29%] hadone child in the home, 13 [13%] had two children, 30 [30%] had more than two children, 28 [28%] had no children.

Regarding the type of family of the subjects 39 [39%] were from nuclear family, 61 [61%] were from joint family.

Regarding the educational status of the subjects 11 [11%] were illiterates, 15 [15%] had primary education, 47 [47%] had higher secondary education, 27 [27%] had degree and above.

Regarding monthly income of the family 9 [9%] were getting Rs- below 1000, 23 [23%] were getting Rs- 1001-3000, 32 [32%] were getting Rs-3001-5000, 36 [36%] were getting above Rs 5000.

Regarding dietary pattern 15 [15%] were vegetarian, 16 [16%] were non vegetarian, 69 [69%] was taking mixed diet.

Regarding personal habits of the subjects 15 [15%] has the habit of taking liquor, 14 [14%] chewed betel leaves, 20 [20%] samples were smokers 51 [51%] have no such habits.

Regarding recreation 30 [30%] clients watch movies, 19 [19%] clients hear music, 15 [15%] read, 20 [20%] converse with others, 16 [16%] has no such habits.

Regarding the influence of mass media 17 [17%] clients watch television 15 [15%] read newspaper, 12 [12%] read posters, 11 [11%] listen to radio, 45 [45%] influence through all the above media.

Regarding family history of cancer 18 [18%] has a family history of cancer, 82 [82%] had no such family history of cancer.

Regarding history of exposure to radiation 19 [19%] had frequent exposure to radiation, 81 [81%] had no exposure to radiation.

Objective-1

The first objective is to assess the existing level of knowledge on prevention of oral cancer.

The result showed that in pretest 39[39%] were inadequate knowledge, 61[61%] were moderately adequate knowledge and none of them having an adequate level of knowledge regarding oral cancer. In post test among the subjects, 79 [79%] were moderately adequate knowledge and 21 [21%] had adequate knowledge regarding oral cancer.

The researcher concluded that in pretest most of the clients havean inadequate knowledge regarding prevention of oral cancer because the samples belongs to rural based setup, lack of awareness regarding oral cancer. This also may be the reason for the inadequate level of knowledge. This is shown by evident that lack of knowledge regardingthe prevention of oral cancer.

The study was supported by

Amarasinghe H K et al (2010) did a study on public awareness of oral cancer, of oral potentially malignant disorders and of their risk factors in some rural population in Sri Lanka, the study was to investigate the level of public awareness of oral cancer, oral potentially malignant disorders and risk factors for developing these diseases in a province of Sri Lanka, a country with one of the highest incidences of these diseases in the world. The study concluded that, knowledge of oral cancer, oral potentially malignant disorders and their associated risk factors was poor among this population, indicated an urgent need to implement public health education and promotion strategies.

The second objective is to find out the effectiveness of video assisted teaching in terms of improving the knowledge regarding prevention of oral cancer.

Mean scores on the level of knowledge was21. 8500 in post test which is significantly higher than, 13.9300 in pre test and computed value of ‘t’ is 17.273 is more than the table value [1.984] at DF [99] which is statistically significant at 0.05 levels. This data shows that video assisted teaching was effective in improving the knowledge regarding the prevention of oral cancer.

The researcher concluded that the video assisted teaching helps to increase the level of knowledge in the prevention of oral cancer. In this study, after the intervention all the samples were improved in level of knowledge. Most of the subjects adopted the positive attitude towards the prevention of oral cancer. The researcher observed that most of the samples responded to the questions very eagerly.

The evidence showed that:

Tanni Botticelli, A. et al.,(2005) Conducted a study to investigate the effectiveness of computer-based video support system during practical training of manual skills and competencies related to periodontal treatment. Eighty four students were randomized into 9 groups: 5 experimental and 4 control groups. On the whole, the students in the experimental group performed significantly better than their colleagues in the control group. Specifically, the groups that utilized the video teaching system performed significantly better in 9 of the 21 procedures tested. These results suggested that computer- based video support can be an effective aid in the teaching of manual skills related to oral health care.

The third objective is to associate the level of knowledge on the prevention of oral cancer and their selected demographic variables such as client age, sex, religion, residence, marital status, no of children, type of family, education, occupation, monthly income, dietary pattern, habits, recreation, exposure to mass media, family history of cancer and exposure to radiation.

For the above objective the researcher concluded that there was a **significant association** between post test knowledge and demographic variables such as personal habits and education because the calculated value is greater than the table value.

There was no significant association between post test knowledge and demographic variables such as age, sex, religion, residence, marital status, no of children, type of family, occupation, monthly income, diet, recreation, family history of cancer and exposure to radiation.

Benard V B et al (2008) examined the association between socioeconomic status and potential human papillomavirus – associated cancers. The study showed that lower education and higher poverty were found to be associated with increased human papillomavirus associated cancer incidence rates. Race was an independent predictor of the development of these potentially human papillomavirus associated cancers.

CHAPTER VI
SUMMARY, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION

This chapter presents the summary of the study, findings and its implications for nursing and health care services and ends with recommendations for further research in this field.

SUMMARY OF THE STUDY

The purpose of the study was to evaluate the effectiveness of video assisted teaching in terms of improving the knowledge regarding prevention of oral cancer among people residing at Manamadurai block.

The experimental study was designed by the researcher to evaluate the level of knowledge. Purposive sampling technique was used to select 100 samples. The tool was developed and adopted after reviewing the relevant literature. The collected data were calculated and analyzed using both descriptive and inferential statistics based on the objectives of the study. The study tested and accepted the hypothesis. The data collected were statistically analyzed and represented as tables and graphs in the previous chapter

MAJOR FINDINGS OF THE STUDY

- The majority of the subjects 27 [27%] were at the age between 18 – 25 years
- The majority of the subjects 55 [55%] were male.
- The majority of the subjects 44 [44%] were Hindus
- The majority of the subjects 66 [66%] live in rural settings.
- The majority of the subjects 63 [63%] were married.

- The majority of the subjects 30 [30%] have more than two children.
- The majority of the subjects 61 [61%] from joint family.
- The majority of the subjects 47 [47%] had a higher secondary education.
- The majority of the subjects 31 [31%] were government employees.
- The majority of the subjects 36 [36%] has monthly income of rupees 5000 and above.
- The majority of the subjects 69 [69%] take mixed diet.
- The majority of the subjects 51 [51%] have no habits of alcohol consumption, chewing betel leaves and smoking.
- The majority of the subjects 30 [30%] watch movies.
- The majority of the subjects 45 [45%] uses the communication media such as television, newspaper, posters and radio.
- The majority of the subjects 82 [82%] has no family history of cancer.
- The majority of the subjects 81 [81%] has no frequent exposure to radiation.
- Majority 61 [61%] subjects were having a moderate level of pretest knowledge regarding the prevention of oral cancer.
- Majority 79 [79%] subjects were having moderate level of post test knowledge regarding the prevention of oral cancer.
- There was a significant association between post test level of knowledge and selected demographic variables such as education and personal habits.

IMPLICATIONS

Oral cancer is one of the major problems in rural population. In order to prevent the oral cancer from the rural population it is essential to educate the rural population regarding prevention of oral cancer. There is a need for health personnel take active part in preparing the rural population for healthy practice in prevention of oral care. Health education program on knowledge regarding the prevention of oral cancer in rural population help in maintaining healthy practices in oral care and also provides psychological support.

The findings of this study have implications in various areas of nursing practice, nursing education, nursing administration and nursing research.

NURSING PRACTICE

Nurses and nursing have a wide scope of primary health the prime concept of the world health organization (WHO). Because health cannot be provided by an agency, it is within every individual. A timely enlightenment will bring numerical changes in health behavior.

- The nurse can practice planned health education program among the rural population to provide adequate knowledge on the prevention of oral cancer.
- The nurse can demonstrate the prevention strategies of oral cancer with active participation of the subjects.
- Nurses practicing in the rural health care setting should be equipped with the knowledge on prevention strategies of oral cancer.

- ❖ The nursing service department can have a group of adequately trained nurses to give health teaching among various levels of rural population.
- ❖ Nursing personnel working in the community should participate in various in service education program to update and improve their knowledge regarding prevention strategies of oral cancer.
- ❖ Health promotion is a vital function. So nurses can use this prevention strategy in their daily life to prevent oral cancer.

Nursing Education

- Nurses at under graduate level need to develop various skills in preparing the materials regarding prevention of cancer for health teaching according to the participant's level.
- Education on oral cancer helps the nursing students to prepare themselves in practicing prevention strategies of oral cancer.
- Student nurses can utilize this technique in health education program to adolescents.

Nursing Research

- Longitudinal research could be done to focus on the behavior modification in relation to oral cancer.
- Further research should aim at new methods of teaching, focusing on interest, quality and cost effectiveness.
- This study also brings about the fact that more studies need to be conducted by using different techniques.

Nursing Administration:

- The nurse administrator should plan to organize educational programs for nursing personnel, in order to prepare them to impart knowledge to the rural population.

- It is the responsibility of the nurse administrator to motivate the nursing personnel to participate and conduct health education programs on various aspects.
- Nursing administrators can utilize this VCD while conducting in service education program regarding prevention of oral cancer.
- Nursing administrators have more responsibility as supervisors in creating awareness among all personnel regarding Prevention of oral cancer by facilitating free distribution of compact disc to workers at all levels of the organization.

LIMITATIONS

- Extraneous variables like age, education, occupation, type of family, religion, exposure to media and place of living were beyond the investigator's control.
- Due to time constraints, 100 samples were used in the study. Therefore generalization is limited.
- The sampling technique used was purposive sampling, which limits the generalization to large populations with similar characteristics.

RECOMMENDATIONS

On the basis of the findings of the study, it is recommended that

1. A study may be done to assess knowledge of the urban population regarding prevention of oral cancer.
2. A comparative study can be done between urban and rural population on the knowledge regarding prevention of oral cancer.
3. A similar study can be replicated with larger sample size and in various other settings.
4. A study can be done to assess the quality of life of patients with oral cancer.

5. A study can be done by using different methods of teaching aids.
6. A comparative study can be done between male and female subjects in rural population.

CONCLUSION

Nurse is a key person for providing care to the patients. Promotion of health, through education is one of the important roles of the nurse. Through education, the subjects can be helped to imbibe healthy practices in their day to day life thus promoting healthy life.

The following conclusions are made based on the above finding that, at pretest, most of the subjects have inadequate level of knowledge regarding the prevention of oral cancer. After assessing the post test level of knowledge, the intervention is proven effective. The study encouraged all the subjects in improving knowledge regarding the prevention of oral cancer. Video assisted teaching showed a effect in improving the level of knowledge regarding the prevention of oral cancer.

APPENDIX-I

LETTER SEEKING EXPERTS' OPINION FOR CONTENT VALIDITY OF THE TOOL

From

Mr. EBIN SAMUEL.J.

M.Sc. Nursing, II Year,

Matha College of nursing, Manamadurai.

To

Through: The Principal, Matha College of Nursing, and Manamadurai.

Respected madam,

Sub: Requisition for getting expert opinion and suggestion for content validity of the tool.

I am a second year master degree student in Matha College of Nursing, Manamadurai in partial fulfillment of Master Degree in Nursing. I have selected the topic mentioned below for the research project to be submitted to the Dr. MGR Medical University, Chennai.

Problem statement:

"An experimental study to assess the effectiveness of video assisted teaching in improving knowledge regarding prevention of oral cancer among people residing at Manamadurai block."

I request you to kindly validate the tool and give your expert opinion for necessary modification and also I will be very grateful if you refine the problem statement and objectives.

ENCLOUSERS:

Statement of the Problem
Objectives
Hypothesis
Research Tool
Demographic profile.

Thanking you

Place: Manamadurai Yours faithfully
Date:

Mr. Ebin Samuel.J.

APPENDIX-II

LIST OF EXPERTS

1. **Dr. R. DIVAKAR, M.B.B.S., M.S.,**
   Consulting Surgeon,
   Sivgangai.

2. **Prof. Mrs. HELEN RAJAMANICKAM., M.SC (N)**
   H O D of community health nursing
   Matha College of nursing, Manamadurai.

3. **Prof. Mrs. SHABEERA BANU., M.SC(N),(PhD)**
   Principal
   Matha College of nursing, Manamadurai.

4. **Prof. Mrs. KALAIGURUSELVI., M.SC(N), (PhD)**
   Vice principal
   Matha College of nursing,Manamadurai

5. **Prof. Mrs. THAMARAI SELVI., M.SC(N), (PhD)**
   Additional vice principal
   Matha College of nursing, Manamadurai

6. **Prof. Mrs. REGINA RANI., M.SC (N). PhD**
   Principal
   Thanthai Rover college of Nursing, Peramballur.

7. **Prof. Mrs. DEVA KIRUBAI., M.SC(N)**
   Professor of Medical Surgical Nursing,
   Sacred Heart College of nursing, Madurai.

8. **Prof. Mrs. MANJULA., M.SC(N)**
   Reader in Medical Surgical nursing
   Sacred Heart College of nursing, Madurai.

APPENDIX-III

LETTER SEEKING PERMISSION TO CONDUCT STUDY

MATHA COLLEGE OF NURSING

(Affiliated to the TamilnaduDr.M.G.R.MedicalUniversity)
Vaanpuram, Manamadurai – 630 606.
Sivagangai District, Tamilnadu

Prof: Shaberabanu, M.Sc., (N), (PhD)

Principal,

To

The panchayat president,

Manamadurai,

Sivagangai District.

Respected Sir / Madam,

Sub: Project work of M.Sc., Nursing student in area around Manamadurai.

I am to state that Mr. EBIN SAMUEL.J. one of our final year M.Sc., Nursing students has to conduct a project, which is to be a partial fulfillment of university requirement for the degree of Master of Science in Nursing.

The topic of research is "an experimental study to assess the effectiveness of video assisted teaching in terms of improving knowledge regarding prevention of oral cancer among people residing at Manamadurai block."

Kindly permit his to do the research work in your rural area.

Thanking you.

Place: Manamadurai.
Date:

Yours faithfully,

Prof. Mrs. Shaberabanu
(PRINCIPAL)

APPENDIX-IV

INFORMED CONSENT

I **Mr. EBIN SAMUEL.J,** II year M.Sc Nursing, in Matha college of nursing, Manamadurai conducting a study **"An experimental study to assess the effectiveness of video assisted teaching in improving knowledge regarding prevention of oral cancer among people residing at Manamadurai block."**as a partial fulfillment of the requirement for the degree of M.Sc (Nursing) under the Tamil Nadu Dr.M.G.R.Medical University. The study participants will be assessed by self modified knowledge assessment questionnaire. I assure you that the response given by you will be kept confidentially. So, I request you to kindly cooperate with me and participate in this study.

Thank you,

APPENDIX-V

CERTIFICATE FOR VALIDATION

This is to certify that the tool developed for data collection by **Mr. EBIN SAMUEL. J,** Final year student of Matha College of nursing, Manamadurai (affiliated to Dr. MGR medical university) is validated and can proceed with this tool and conduct the main dissertations entitled “An experimental study to assess the effectiveness of video assisted teaching in terms of improving knowledge regarding prevention of oral cancer among people residing at Manamadurai block.”

Date:

Signature:

APPENDIX-VI

CERTIFICATE OF ENGLISH EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation work ***"An experimental study to assess the effectiveness of video assisted teaching in terms of improving knowledge regarding prevention of oral cancer among people residing at Manamadurai block."*** Done by **Mr. EBIN SAMUEL.J,** II year M.Sc Nursing, in Matha College of nursing, Manamadurai is edited for English language is appropriate.

Signature:

APPENDIX – VII

PART – A

DEMOGRAPHIC DATA

Choose the right answer from the given options:

1. Age of the client (in year)
   a) 18 – 25
   b) 26 – 35
   c) 36 – 45
   d) Above 46 years

2. Sex
   a) Male
   b) Female

3. Religion
   a) Hindu
   b) Christian
   c) Muslim

4. Residence
   a) Rural
   b) Urban

5. Marital Status
   a) Married
   b) Unmarried
   c) Widow
   d) Divorced

6. Number of Children
   a) One
   b) Two
   c) More than Two
   d) None

7. Type of Family
    a) Nuclear Family
    b) Joint Family

8. Education
    a) Illiterate
    b) Middle School level
    c) Higher Secondary level
    d) Graduate and Above

9. Occupation
    a) Unemployed
    b) Coolie Worker
    c) Government Employee
    d) Private Employee
    e) Business

10. Monthly Income (Rupees)
    a) Below 1000
    b) 1001 – 3000
    c) 3001 – 5000
    d) Above 5000

11. Dietary Pattern
    a) Vegetarian
    b) Non – Vegetarian
    c) Mixed Diet

12. Habits
    a) Alcohol Consumption
    b) Betel Chewing
    c) Smoking
    d) None of the above

13. Hobbies
    a) Watching Movie
    b) Listening Music
    c) Reading Books
    d) Chatting
    e) None

14. Exposure to mass media
    a) Television
    b) Newspaper
    c) Posters
    d) Radio
    e) All the above

15. Family history of cancer
    a) Yes
    b) No

16. Frequent exposure to radiation
    a) Yes
    b) No

APPENDIX – VIII

T¥Ym – A

R²STo ®TWeLs
¸rLiPYt±p N¬Vô] T§ûX úRoÜ ùNnVÜm

1. **YVÕ (YÚPeLs)**
   - **A) 18-25** **B) 26-35**
   - **C) 36-45** **D) 46dÏ úUp**
2. **C]m**
   - **A) Bi**
   - **B) ùTi**
3. **URm**
   - **A) CkÕ**
   - **B) ¡±vRYm**
   - **C) CvXôm**
4. **Eû\®Pm**
   - **A) ¡WôUm**
   - **B) SLWm**
5. **§ÚUQjRÏ§**
   - **A) §ÚUQUô]Yo**
   - **B) §ÚUQUôLôRYo**
   - **C) ®RûY**
   - **D) ®YôLWjRô]Yo**
6. **ÏZkûRL°u Gi¦dûL**
   - **A) Juß** **B) CWiÓ**
   - **C) CWi¥tÏ úUp** **D) CpûX**
7. **ÏÓmT AûUI×**

A) R²dÏÓmTm

B) áhÓdÏÓmTm

8. Lp®

A) T¥ÌT±®pXôRYo

B) SÓ¨ûXdLp®

C) EVo¨ûXdLp®

D) ThPRô¬ Utßm ARtÏm úUp

9. ùRô¯p

A) úYûX YônlTt\Yo

B) á- úYûX

C) AWNôeL F¯Vo

D) R²Vôo F¯Vo

E) ÑV ùRô¯p

10. UôR YÚUô]m (ìTôn)

A) 1000 ìTôndÏ ¸r

B) 1001 – 3000

C) 3001 – 5000

D) 5000dÏ úUp

11. EQÜØû\

A) ûNYm

B) AûNYm

C) CWiÓm LXkR EQÜ

12. TZdLYZdLeLs

A) UÕTô]m AÚkÕRp

B) ùYt±ûX TôdÏ ùUpÛRp

C) ×ûLI©¥jRp

D) GÕÜªpûX

13. ùTôÝÕúTôdÏ

A) TPm TôoITÕ

B) CûN úLhTÕ

C) ×jRLm T¥jRp

D) EûWVôÓRp

E) GÕÜªpûX

14. TVuTÓjRITÓm RLYp ùRôPo× NôR]eLs

A) ùRôûXdLôh£ ùTh¥

B) ùNn§jRôs

C) ÑYùWôh¥ ®[mTWeLs

D) Yôù]ô-IùTh¥

E) úUtá±V Aû]jÕm

15. ÏÓmTj§p VôÚdúLàm ×tßúSôn CÚd¡\Rô?

A) Bm

B) CpûX

16. L§oÅfÑ EeLs ÁÕ A¥dL¥ TÓYÕiPô?

A) Bm

B) CpûX

APPENDIX – IX

PART – B

Choose the best answer from the given options:

1. Oral Cancer refers to
    a) Malignant growth of tissues in oral cavity
    b) Non healing ulcers
    c) Necrosis of oral tissues
    d) I don’t know

2. Most vulnerable age group for Oral Cancer
    a) 20 – 30 Yrs.
    b) 30 – 40 Yrs.
    c) 40 – 50 Yrs.

d) 50 – 60 Yrs.

3. Most Oral Cancer is related to excessive use of
   a) Tobacco, Beta Nut, Snuff
   b) Coffee
   c) Tea
   d) I don't know

4. Oral Cavities are injured by excessive intake of
   a) Hot and spicy food
   b) Oily food
   c) Beverages
   d) I do not know

5. Physical factors that can cause Oral Cancer
   a) Ultraviolet radiation exposure
   b) Exposure to X-Rays
   c) Both a & b
   d) None of the above

6. Nutritional factor that can cause Oral Cancer
   a) Deficient in fruits and vegetables
   b) High fat rich food
   c) High protein rich food
   d) I do not know

7. Most common causative organism for Oral Cancer
   a) Human immunodeficiency virus
   b) Human Papilloma virus
   c) Rota virus
   d) I do not know

8. A vegetables that is considered as a risk factor of Oral Cancer
   a) Brinjal
   b) Tomato

c) Carrot
d) Cucumber

9. Risk factor for Oral Cancer in Non smokers and Non alcohol consumption groups are
   a) Hereditary
   b) Unhygenic food practices
   c) Malnutrition
   d) I do not know
10. Early symptoms of Oral Cancer
   a) Ulcer on tongue, lip or other mouth areas
   b) Burning sensation in oral cavity
   c) Teeth discoloration
   d) I do not know

11. Later symptoms of Oral Cancer is
   a) Swallowing difficulties
   b) Mouth sores that do not resolve in 14 days
   c) Pain and Parasthesia
   d) All the above

12. The prevalence of Oral Cancer is high among
   a) Men
   b) Women
   c) Children
   d) Old age

13. How to rule out Oral Cancer
   a) Brush biopsy (Brush test)
   b) Tissue biopsy
   c) Both a&b
   d) I do not know

14. Oral Cancer in Rural areas can be detected by
   a) Conducting dental camps
   b) telemedicine

c) Both a & b
d) I do not know

15. Oral Cancer can spread to which parts of the body
    a) Nasal Cavity
    b) Oesophagus
    c) Trachea
    d) All the above

16. Prognosis of Oral Cancer is based on
    a) Early Diagnosis
    b) Body Condition
    c) Age
    d) I do not know

17. Majority of the oral cancers remain un-noticed due to
    a) Illiteracy
    b) Ignoring the colour changes and soreness in oral cavity
    c) Lack of awareness
    d) I do not know

18. If the mouth lesions are not treated, it leads to
    a) Change in tooth colour
    b) Mouth cancer
    c) Speech disturbances
    d) I do not know

19. Oral Cancer can be prevented by
    a) Proper Oral Hygiene
    b) Regular intake of fluoride
    c) Regular intake of fat rich food
    d) I do not know

20. How maintain adequate nutrition for Oral Cancer patients
    a) Total parental nutrition
    b) Feeding tube

c) IV Fluids
d) I do not know

21. Most common management of Oral Cancer
    a) Antibiotic
    b) Radiation therapy
    c) IV Fluids
    d) I do not know

22. Disfigurement due to Oral Cancer can be corrected by using
    a) Reconstructive surgery (cosmetic)
    b) Bone grafts and surgical flaps
    c) Both a & b
    d) I do not know

23. Side effects of chemotherapy and radiation treatment is
    a) Diarrhea
    b) Alopecia
    c) Fever
    d) All the above

24. Rehabilitation is necessary to improve
    a) Chewing and Speech
    b) Self Esteem
    c) Tissue Growth
    d) All the above

25. What is the reason for not knowing Oral Cancer in our country
    a) Lack of awareness (Public)
    b) Lack of Medical Supplies
    c) Illiteracy
    d) All the above

Answers:

1. a	11. d	21. b
2. c	12. d	22. c
3. a	13. c	23. b
4. c	14. a	24. a
5. c	15. d	25. d
6. a	16. a	
7. b	17. b	
8. b	18. b	
9. a	19. a	
10. a	20. a	

APPENDIX – X

T¥Ym – B

அறிவு திறன் கேள்விகள்

1. YônI ×tßúSôn GûRd Ï±d¡\Õ?
   - A) Yô«p Y[Úm A§úYL §ÑdL°u Y[of£
   - B) ¾WôR YônI×i
   - C) Yô«p LôQlTÓm C\kR §ÑdLs
   - D) G]dÏ ùR¬V®pûX

2. YônI×tßúSôn GkR YV§]ûW G°§p RôdÏm?
   - A) 20 – 30 YVÕ
   - B) 30 – 40 YVÕ
   - C) 40 – 50 YVÕ
   - D) 50 – 60 YVÕ

3. GRû] A§Lm TVuTÓjÕYRôp YônI×tßúSôn HtTÓ¡\Õ?
   - A) ×ûL«ûX, TôdÏ, êdÏlùTô¥
   - B) LôI©
   - C) úR«ûX
   - D) G]dÏj ùR¬VôÕ

4. GRû] A§Lm EhùLôsÞYRôp YônITÏ§ Tô§ITûP¡\Õ?
   - A) ãPô] Utßm YôNû]ëhÓm EQÜ
   - B) GiùQn RuûU ¨û\kR EQÜ
   - C) Tô]eLs
   - D) G]dÏj ùR¬VôÕ

5. YônI×tß úSôûV HtTÓjÕm CVtûL LôW¦Ls
   - A) ×\ FRôd L§oL°u FÓÚYp
   - B) GdvúW L§oL°u FÓÚYp
   - C) úUtá±V CWiÓm
   - D) úUtá±V GÕÜªpûX

6. YônI×tß HtTÓjÕm FhPfNjÕ LôW¦Ls
   A) LônL± Utßm TZeLs Tt\ôdÏû\
   B) A§L ùLôÝI× ¨û\kR EVoRW EQÜ
   C) A§L ×WRfNjÕ ¨û\kR EQÜ
   D) G]dÏR ùR¬VôÕ

7. A§LUô] YônI×tß HtTÓjÕm ¡Úª
   A) Gf.I.®.
   B) úTI©úXôúUô ûYWv
   C) úWôhPô ûYWv
   D) G]dÏj ùR¬VôÕ

8. GkR LônL±dÏ YônI×tß HtTÓjÕm §\u Es[Õ?
   A) LjR¬dLôn
   B) RdLô°
   C) LôWh
   D) ùYs[¬dLôn

9. ×ûLITZdLm Ï¥ITZdLm CpXôRYÚdÏ YônI×tß HtTÓYRtLô] LôWQm
   A) TWmTûW
   B) ÑLôRôWUt\ EQÜ TZdLYZdLeLs
   C) N¬®¡R EQÜ CpXôRÕ
   D) G]dÏj ùR¬VôÕ

10. YônI×t±u BWmT A±Ï±
   A) SôÜ, ERÓ UtßU Yôn NôokR CPeL°p HtTÓm ×i
   B) Yôn G¬fNp
   C) Tp ¨\UôßRp
   D) G]dÏj ùR¬VôÕ

11. YônI×tß úSôn Øt±V ¨ûX«p HtTÓU A±Ï±Ls
    A) EQûY ®ÝeÏm úTôÕ £WUm HtTÓRp
    B) 14 SôhLÞs YônI×I ¾WôU-ÚI©u
    C) Y- Utßm EQoYt\ RuûU
    D) úUtá±V Aû]jÕm

12. TWYXôL YônI×iQôp Tô§dLITÓYÕ
    A) Bi
    B) ùTi
    C) ÏZkûRLs
    D) Ø§oYV§]o

13. YônI×tß GRu êXm LiP±VITÓ¡\Õ?
    A) ©Wv T¬úNôRû]
    B) §Ñ T¬úNôRû]
    C) úUtá±V CWiÓm
    D) G]dÏj ùR¬VôÕ

14. ¡WôUI×\eL°p YônI×tû\ GqYôß LiP±VXôm?
    A) TpúSôn UÚjÕY ØLôm SPjÕYRôp
    B) SPUôÓm UÚjÕYdÏÝ
    C) úUtá±V CWiÓm
    D) G]dÏj ùR¬VôÕ

15. YônI×tß EP-p GkR TÏ§LÞdÏ TWÜ¡\Õ?
    A) êdÏlTÏ§
    B) EQÜdÏZôn
    C) êfÑdÏZôn
    D) úUtá±V Aû]jÕm

16. YônI× úSô«u Øuú]t\m GRu A¥ITûP«p AûUÙm?
    A) BWmT ¨ûX«p LiÓ©¥ITRôp
    B) EPp¨ûX
    C) YVÕ
    D) G]dÏj ùR¬VôÕ

17. YônI×tß úSôûV ùTÚmTôuûUúVôo A±VôRRu LôWQm

A) T¥IT±®uûU

B) YônITÏ§ ¨\Uôt\m Utßm ×iLû[ùTôÚhTÓjRôûU

C) A§L ®¯I×Qo®uûU

D) G]dÏj ùR¬VôÕ

18. Yô«p HtTÓm ùY¥I×Lû[ÏQITÓjR®pûXùVu\ôp HtTÓm ®û[Ü?

A) Tp ¨\UôßRp

B) YônI ×tßúSôn

C) úTfÑ RÓUôt\m

D) G]dÏj ùR¬VôÕ

19. YônI×i GqYôß R®odLITÓ¡\Õ?

A) YôûV çnûUVôL ûYjRp

B) §]Øm (×ÞûWh) EhùLôsÞRp

C) §]Øm ùLôÝI× ¨û\kR EVoRW EQûY EhùLôsÞRp

D) G]dÏj ùR¬VôÕ

20. YônI×tß úSôVôp Tô§dLIThPYoL°u EP-p FhPfNjÕ ºWôL ûYITÕ GIT¥

A) CWjRj§u êXm FhPfNjûR HtßRp

B) ÏZôn Y¯VôL EQûYd ùLôÓITRôp

C) SWm©u êXm ùNÛjRITÓm F£ UÚkÕ

D) G]dÏj ùR¬VôÕ

21. YônI×tßdLô] ùTôÕYô] £¡hûN Øû\

A) úSôn G§oI× UÚkÕ

B) L§oÅfÑ

C) SWm©u êXm ùNÛjRITÓm F£UÚkÕ

D) G]dÏj ùR¬VôÕ

22. YônI×t±p HtTÓm EÚY Uôt\eLû[N¬ ùNnÙU Øû\Ls
A) ØLfºWûUI× £¡hûN
B) GÛm× Utßm RûN Uôtß AßûY £¡hûN
C) úUtá±V CWiÓm
D) G]dÏj ùR¬VôÕ

23. úY§f£¡hûN Utßm L§oÅfÑ £¡hûN«u TdL ®û[ÜLs
A) Y«tßIúTôdÏ
B) Ø¥E§oRp
C) LônfNp
D) úUtá±V Aû]jÕm

24. YônI×t±-ÚkÕ ÁsTYûW ×]WûUITRu êXm GûR A§LITÓjR Ø¥Ùm?
A) ùUpÛRp Utßm úTfÑjRuûU
B) Ru]m©dûL
C) §ÑdL°u Y[of£
D) úUtá±V Aû]jÕm

25. SmSôh¥p YônI×tß úSôn Tt± UdLÞdÏ ùR¬VôRRtLô] LôWQm?
A) A§L ®¯I×Qo®uûU (ùTôÕUdLs)
B) A§L UÚjÕY ETLWQªuûU
C) Lp®V±®uûU
D) úUtá±V Aû]jÕm